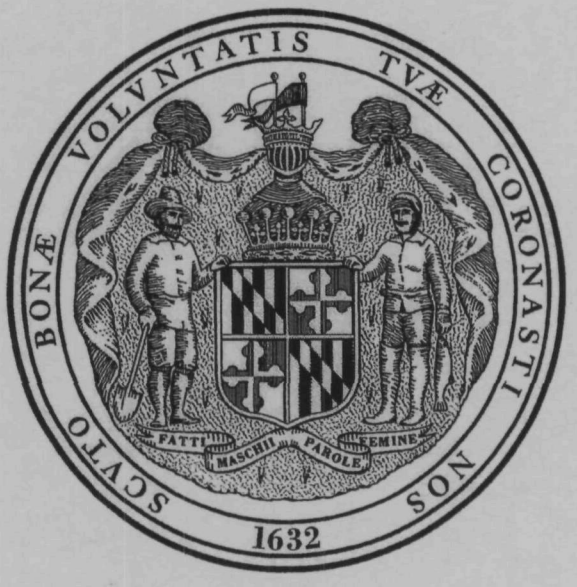

REPORT OF THE TASK FORCE TO STUDY THE HEALTH CARE NEEDS OF INMATES IN TRANSITION FROM CORRECTIONAL INSTITUTIONS

JUNE 2002

Parris N. Glendening
Governor

Kathleen Kennedy Townsend
Lt. Governor

Delegate Rudolph C. Cane
Chair

Task Force to Study the Health Care
Needs of Inmates in Transition from
Correctional Institutions

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TASK FORCE TO STUDY THE HEALTH CARE NEEDS OF INMATES IN TRANSITION FROM CORRECTIONAL INSTITUTIONS

"[W]e need a program to assist [with] the discharging of prisoners back into society. ...[W]e want to link you to primary medical care for a smooth transition so you have the resources necessary to experience a better life."

DELEGATE RUDOLPH CANE, TASK FORCE CHAIR

"If we don't solve the problem of transition, we are not going to solve the problem that got you into prison in the first place."

SENATOR ANDREW HARRIS, TASK FORCE MEMBER

"[W]e have to work very hard to make sure that people...get the care they need."

DELEGATE SHIRLEY NATHAN-PULLIAM, TASK FORCE MEMBER

INTRODUCTION

The Task Force to Study the Health Care Needs of Inmates in Transition from Correctional Institutions was convened by appointment of Governor Paris N. Glendening in accordance with Chapter 466 of the Acts of 2000 (House Bill 1232).

The Task Force was charged with:

- Examining the scope of the problems faced by prison inmates who are released with health care needs;
- Collecting data to determine the correlation between health care needs of released inmates with diabetes, HIV, viral hepatitis, substance abuse addiction, and sexually transmitted diseases, and the commission of crimes;
- Determining the extent to which health care programs are accessible to inmates with health care needs upon their release;
- Determining the availability of medication and health insurance for inmates with health conditions upon their release;
- Making recommendations to increase the availability of both short-term and long-term health care programs for recently released inmates; and
- Submitting a report of its findings, recommendations, and comprehensive strategy to the Governor and the General Assembly by July 1, 2001 (The deadline was extended until July 1, 2002 per Chapter 296 of the Acts of 2001).

A listing of the Task Force membership is attached in the appendix.

The goals and duties of the Task Force were accomplished through site visits of correctional institutions across the state; discussions with inmates, correction officers,

medical staff and administrators at these facilities; presentations from numerous organizations, agencies, and interested parties; and a review of scientific and other literature related to programs operating in other states that seek to address the health care needs of inmates in transition and any measurable outcomes associated with these programs.

Members of the Task Force toured several correctional institutions across the state including: Eastern Correctional Institution in Westover on Maryland's lower Eastern Shore, Maryland Correctional Institution - Hagerstown in Western Maryland, the Baltimore Central Booking and Intake Center, the Patuxent Institute in Jessup, and Maryland Correctional Institution – Women in Jessup. Discussions were held between members of the Task Force and inmates, administrators, corrections staff, and medical providers about the barriers to arranging and obtaining health care after the inmate's release back to the community.

A Town Hall Meeting was held at Baltimore's War Memorial Building to solicit input from the community about the needs of and challenges facing newly released inmates. Ex-offenders, community providers, voluntary organizations serving ex-offenders, advocacy groups, legislators, and other interested parties addressed the Task Force, relating their experiences and difficulties in obtaining or providing healthcare and other services following release from incarceration.

CURRENT CIRCUMSTANCES OF INMATES IN TRANSITION

The Task Force obtained data to determine the scope of need that exists for inmates in Division of Correction facilities. Using a survey of institutions across the State, the Task Force was able to determine the average daily population across State correctional facilities and the prevalence of eight chronic and four infectious diseases among this average population of inmates. The results indicate that there is a serious need for access to appropriate health care for inmates who will transition back to their communities.

The population of all of the Division of Correction facilities throughout the State averages 34,626 inmates on any given day. Of these 34,626 inmates, a total of 4,086 have been diagnosed with an infectious disease[1] including 2,482 inmates diagnosed with HIV/AIDS.

In addition, 3,936 inmates suffer from a significant medical condition. This number includes, but is not limited to, the following: 1,197 inmates suffering with asthma, 503 inmates suffering with diabetes, 1,474 inmates suffering with hypertension, and 321 inmates suffering from seizures.[2]

The total average number of inmates who have a current infectious disease or a significant medical condition is equal to 8,022 inmates. This is equivalent to roughly 23

[1] Presentation by Anthony Swetz, Jr., Ph.D., *Correctional Facilities Medical Care Clinic Statistics*, Task Force Meeting, July 31, 2001.
[2] *Id.*

percent of the average daily prison population of the State having a documented need for medical treatment.

Substance abuse and mental illness are common health issues among released inmates. About 80 percent of this population across the United States has a history of substance and alcohol abuse, and an estimated 16 percent suffer from mental illness.[3] In Maryland, 85 percent of the people processed at the Baltimore Central Booking and Intake Center report that they engage in drug use.[4] An estimated two-thirds of untreated injection drug users resume their heroin/cocaine use and patterns of criminal behavior within three months of their release.[5] Studies also indicate that from 4 to 9 percent of the offender population has mental retardation.[6] A disproportionate share of the prison population also lives with chronic health problems or infectious diseases.

HEALTH-RELATED SERVICES AVAILABLE TO INMATES IN TRANSITION

Over 70 percent of inmates incarcerated in facilities throughout the State will be returning to Baltimore City upon their release. Even in facilities where pre-release planning is done, the great distance between the facility holding the inmate and the community to which s/he will return serves as a handicap to pre-release planners.

Indigent inmates who are in transition from prison back into their communities must rely heavily on State and Local health departments to meet their immediate health care needs. These publicly funded systems of care are already overburdened by the need to provide, with limited funding, medical care to the general public. Programs such as Medicaid, Maryland Pharmacy Assistance Program (MPAP), Maryland PrimaryCare, the U.S. Department of Veteran's Affairs, Federally Qualified Health Centers, Baltimore Mental Health System, Ryan White Clinics, and Maryland AIDS Drug Assistance Program (MADAP) have different eligibility requirements, enrollment processes, and benefits or services. Loss of benefits and personal identification once a detainee is confined, create additional challenges for the inmate who is returning to the community. Inmates in transition must be aware of what programs exist, know where and how to apply for the benefits, and in most cases wait at least 30 days for determination of eligibility even where eligibility had been previously established. With an expedited eligibility determination process that occurs within 48 hours of application, MADAP-90 is a program that serves as a bridge to provide HIV/AIDS medications coverage to qualified individuals for up to 90 days, less if the individual enrolls in another program such as Medicaid, MPAP or MADAP.

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[3] Taxman, F, Ph.D. The Eight Reentry Partnership Initiatives. Bureau of Governmental Research-University of Maryland.

[4] Per February 10, 1999 conversation with Lamont W. Flanagan, Commissioner, Maryland Department of Public Safety and Correctional Services, Division of Pretrial Detention Services.

[5] Pelissier, B.M.M. et, al. "Triad Drug Treatment Evaluation Project-Six Month Interim Report." Federal Bureau of Prisons. Jan. 31,1998.

[6] National Institute of Corrections. Provision of Mental Health Care in Prisons. Feb 2001.

A few non-profit programs that are scattered sparsely across the state are often the only other option available to post-release inmates who have no private health insurance and do not qualify for public programs. One such program is the Vision for Health Care Consortium that operates in the Baltimore community of Sandtown-Winchester. In collaboration with the Baltimore City Health Department, this center serves the health care needs of approximately 30 uninsured men a day, many of whom are ex-offenders and who are not eligible for any government health plan. Prisoners Aid Association of Maryland is another example of a non-profit organization that assists former inmates with medical and pharmacy benefits among other services.

According to Ms. Malinda Miles of Prisoners Aid Association of Maryland, *...There are gaps in the health care system when it comes to inmates. ... We try to get them into other medical facilities and because they don't have health insurance no one will take them. ...They go to the emergency room for treatment."* [7]

Also noteworthy are several support groups and non-profit associations across the State that, although not able to provide assistance for physical health care needs, seek to provide faith-based guidance and general social and emotional support for inmates trying to reenter society from the prison system.

IDENTIFIED GAPS AND AREAS OF NEED

The leading issue that was raised repeatedly by all stakeholders (current inmates, former inmates, correctional facility staff and administration, and advocates) was **the need for timely transition planning**, also known as discharge or pre-release planning. Timely was generally defined as pre-release planning that started at least **three months prior to release, with up to six months being recommended**. For the inmate in transition, pre-release planning is typically broader than medical discharge planning. Other issues that need to be addressed include housing, employment, education and other needs upon release. Numerous stakeholders identified these broader issues as gaps in pre-release planning. However, for the purposes of this Task Force, the report will focus specifically on health care needs.

In addition to the importance of timely pre-release planning, several other specific areas were identified as significant barriers faced by inmates with health care needs who are in transition back to their communities.

- **Access to and availability of substance abuse and mental health treatments** were the most common health care needs identified by all stakeholders. For substance abuse, access to and availability of appropriate treatment modalities were also often mentioned.

[7] Ms. Malinda Miles of Prisoners Aid Association quoted at the Town Hall Meeting, Baltimore's War Memorial Building, July 19, 2001.

- Correctional facility staff and administration noted the **lack of staff and financial resources to provide timely and comprehensive pre-release planning** for most inmates. Low salary scale and working environment were the most often-cited staff recruitment and retention problems.

- **Difficulties in recruiting and retaining staff** in correctional facilities often exacerbate an already seemingly impossible job. With an average of 13,500 inmates released each year and only 45 social workers, the caseload is too large to enable the provision of even the most basic pre-release planning for most inmates. Compounding the problems created by **over burdensome caseloads** are **computer and information technology systems that are many generations old**. These systems are inadequate to be used for networked or multiple tasks such as tracking an inmate's sentence and likely release date, and medical records, all complicating the ability to adequately plan in advance for pre-release. An additional challenge for timely pre-release planning is the occasional inmate who is suddenly released.

- **The loss of health benefits such as Medicaid** upon detention or incarceration is another significant barrier recognized by numerous stakeholders. Once released, the former inmate must reapply for benefits, which can take a minimum of 30 days.

- Also cited as barriers were: **multiple, complex diagnoses; lack of identified primary care providers in the community; lack of a follow-up plan** for care once in the community; **inadequate supply of medication** upon release while awaiting follow-up care and possible medical benefits; **lack of money** to access follow-up care, medication, supplies, etc. once released; **lack of transportation** to providers; and the **limited knowledge** of inmates about his or her own medical diagnosis, treatment, and disease management needs.

- **Lack of coordination of services among federal, state, local, and community agencies** to optimize discharge planning, health care services, and benefits was also seen as a significant barrier that compounds already existing problems.

SUCCESSES

Model programs to treat current inmates and those in transition who have HIV/AIDS were consistently deemed successful by stakeholders. These programs are the result of a collaborative effort between the Department of Public Safety and Corrections Services (DPSCS) and the Department of Health and Mental Hygiene, AIDS Administration.

Pre-release planning for inmates in transition who are mentally retarded was also noted as being effective.

RECOMMENDATIONS OF THE TASK FORCE

- Pre-release planning must be accomplished in advance of the inmate's release, allowing sufficient time to apply for and secure benefits so they are immediately available upon the inmate's release. Planning should begin, at a minimum, three to six months prior to release.

- The use of students and interns from the helping professions should be explored to facilitate pre-release planning for inmates and enhance educational experiences for the students and interns.

- As part of pre-release planning and prior to release, inmates should be provided with appropriate medical release forms, allowing medical records to be sent to providers who may be treating the released inmate in the community.

- The Department of Public Safety and Corrections Services (DPSCS) should be supported in efforts to secure additional information technology and staff resources to assist in the implementation of pre-release planning including health care.

- DPSCS should be supported in the development of an automated health care information management system.

- DPSCS should be supported in efforts to secure additional resources to develop a system-wide computer database that would include for each inmate: length of sentence, good time credits, projected release date and locality. Ideally this system would have the capability of interfacing with the automated health care information management system to provide seamless pre-release planning.

- A cooperative agreement for a common benefits application should be established among State agencies and programs administering benefits to facilitate an inmate's benefits determination prior to release.

- DPSCS and the United States Department of Veterans Affairs should develop a closer relationship to facilitate post-release care for eligible inmates who are veterans.

SELECT PILOT AND MODEL PROGRAMS ASSISTING INMATES IN TRANSITION

The problems faced by inmates in transition from correctional facilities are not unique to the state of Maryland. States across the nation are trying to find solutions to similar issues related to access to health care treatment as well as problems that inmates have when

reentering the community associated with finding housing, a job, opportunities for continuing education, and social support.

A number of states throughout the country have implemented or are in the process of implementing specialized programs to deal with many of these issues. Components of some of these programs may serve as models for use in Maryland.

An ongoing evaluation of a residential drug treatment program within the **Federal Bureau of Prisons** has shown a reduction in recidivism and relapse rates. Results indicate that inmates who completed the residential treatment program were 73 percent less likely to be re-arrested than inmates who went untreated. The most successful outcomes were found among those who participated in treatment while in prison and continued with community-based treatment during their post-release supervision.

Results from a prison based drug treatment program operating in the **State of Delaware** offer additional evidence that for drug treatment to be optimally effective it should begin early and continue for as long as needed, sometimes months or even years. Drug abuse offenders who received 12 to 15 months of treatment in prison followed by an additional 6 month of drug treatment in combination with job skills training were more than twice as likely to be drug-free than offenders who received treatment only while in prison. The additional 6 months of post-release treatment and job skills training are provided by the Crest Center in Delaware, the first therapeutic community work-release center in the nation.

A program that works with the jail population in **Hampden County, Massachusetts** provides intensive screening to inmates upon their arrival to prison, education on health issues throughout their incarceration, and access to regular long-term health care during their jail stay and after release. The program began in 1992 with an HIV awareness course, and now provides comprehensive medical services to inmates through contractual arrangements with established non-profit community health centers. Each inmate is assigned to a physician and caseworker, and these assignments provide continuous long-term health care to an inmate during his/her stay and after release. The effects of the program are impressive: 100 percent of Hampden jail inmates are provided with a complete physical during their stay, and 90 percent of the inmates keep medical appointments after they have been released back into the community. The Hampden County recidivism rate stands at 9 percent, far lower than rates for comparable correctional facilities.[8]

The **Florida** Department of Correction has created an Inter-Agency Advisory Committee Task Force, which is a collaboration among jails, prisons, county health departments, and community HIV providers. The main goal of the task force is to bridge any gaps between services for HIV infected inmates and to support a continuity of care. As one method of reaching this goal a training program is being created for physicians that will be a mini-residency in the treatment and care of HIV. The program has just started, and is funded by an unrestricted grant through a local college, the funding being provided by a pharmaceutical company.

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[8] California Department of Corrections - Preventing Parolee Failure Program.

The **Rhode Island** Department of Health in cooperation with the Rhode Island Department of Corrections and Brown University's AIDS Program-have instituted a practical, low cost, and effective program for providing HIV-infected inmates with health care during and after incarceration. A study of the program for HIV-seropositive women inmates shows that the program appears to reduce the recidivism rate and decreases the former inmates' high-risk behavior. T. Flanigan, M.D., Director of the Immunology Center at Miriam Hospital believes that academic medical centers are uniquely positioned to assume the leading role in providing care for HIV-infected prisoners.

The **State of Maryland** also has several programs, some in pilot phase that may be appropriate to replicate in other areas of the State. Many of the programs operating in Maryland currently are largely focused on the health care needs of inmates living with HIV and AIDS. This lends further credence to comments made by many of those who were interviewed at correctional facilities across the state of Maryland. Inmates, facility administrators, prison health care providers, and case managers all indicated that inmates who were HIV positive or living with AIDS had a far better chance than any others to receive adequate health services both in jail and in the community upon their release.

The Prevention Case Management Program is a voluntary pre-release HIV/AIDS prevention program for inmates in State correctional facilities and local detention centers throughout **Maryland.** It is designed to be an intensive counseling service targeted to persons with HIV infection as well as those unaware of their serostatus, but engaged in high risk behaviors. Clients enrolled in the program receive one-on-one counseling sessions aimed at reducing HIV risk behavior and facilitating transition back into the community. The program serves approximately 700 clients per year.

The **Maryland** Correctional Options Program (COP) provides intensive community management of selected offenders, and substance abuse treatment to alcohol and drug addicted offenders in an attempt to prevent recidivism. Some of the correctional options used are:

a. Regimented Offender Treatment Center (ROTC) -This program is housed in the Patuxent Institute. It serves as an inpatient substance abuse treatment center.
b. Intensive Supervision Probation (ISP) -This program, used in monitoring drug offenders, focuses on stabilizing the offender. It provides more intensive surveillance of offenders than standard supervision.
c. Patuxent Re-Entry After Care Center (Baltimore City) -These are certified treatment and aftercare programs intended to be outpatient programs for offenders who completed ROTC or outpatient treatment in the community. The emphasis is on staying drug-free and providing support for offenders who were/are substance abusers.
d. Baltimore Pre-Release Center for Women -This program consists of 90 days of counseling and treatment for drug addiction, parenting and life skills classes, and domestic violence education before release from incarceration.

e. Drug Court (Baltimore City) -This is a front-end diversionary program that allows drug-addicted offenders to be diverted into drug treatment alternative sanctions in lieu of prosecution or as a sentencing option.

The **Maryland** Re-Entry Partnership Initiative (MRPI) program is funded with federal dollars and grants and has 68 active clients with a 78 percent retention rate. Since it began in January 2001, the program has experienced only three violations of parole or probation.

The MRPI receives the names of inmates 90 days prior to their release and requests that Parole and Probation agents visit the inmate in prison to establish a relationship. Through community case managers and advocates, newly released inmates are linked with housing, employment, education and health care. All advocates are ex-offenders who serve as role models of success for the inmates. Although not exclusively focused on health care, a health screening within 72 hours of release is part of each inmate's program plan.

Although the results of these programs are encouraging, the reality is that these programs are severely limited in the number of inmates they can serve because of funding and staffing constraints. The need for services greatly outweighs the capacity that exists to provide them. Unfortunately this lack of treatment and support contributes to exponentially growing problems related to a revolving door of inadequate treatment, criminal behavior, drug addiction, mental illness, and recidivism.

APPENDIX I

LIST OF TASKFORCE MEMBERS

TASK FORCE TO STUDY THE HEALTH CARE NEEDS OF INMATES IN TRANSITION FROM CORRECTIONAL INSTITUTIONS

MEMBERS

Appointees:

Delegate Rudolph C. Cane, *Chair*

Senator Joan Carter Conway
Senator Andrew P. Harris
Delegate Shirley Nathan-Pulliam
Charles P. Anderson
Jescina F. C. Artis
David L. Butcher, M.D.
Jay H. Cutler
Grady Dale, Jr., Ed.D.
Colene Y. Daniel
Marvelyn A. Fowler
George W. Giese
Andrew I. Holton, Jr.
Barbara A. McLean, M.D.
Leroy Mobley
Judith S. Sachwald
Marion S. Sjodin
Liza Solomon, Dr. P.H.
Anthony Swetz, Jr., Ph.D.
Ralph E. Washington

Howard C. Cohen, *Staff*
Grace S. Zaczek, *Staff*

Additional Representatives:

Ramona Dixon-Smith
Michele Douglas
Sharon Morris
Gerald Stewart

APPENDIX II

LETTERS

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

300 E. JOPPA ROAD - SUITE 1000
TOWSON, MARYLAND 21286-3020
PHONE (410) 339-5000 ♦ FAX (410) 339-4240
V/TTY FOR THE DEAF 1-800-735-2258
(MARYLAND RELAY SERVICE)
TOLL FREE 1-877-379-8636
WEB SITE: www.dpscs.state.md.us

PARRIS N. GLENDENING
GOVERNOR

KATHLEEN KENNEDY TOWNSEND
LT. GOVERNOR

STUART O. SIMMS
SECRETARY

Agencies:

The Division of Correction

The Division of Parole and Probation

The Division of Pretrial Detention and Services

The Patuxent Institution

The Maryland Commission on Correctional Standards

The Correctional Training Commission

The Police Training Commission

The Maryland Parole Commission

The Criminal Injuries Compensation Board

The Emergency Number Systems Board

The Sundry Claims Board

The Inmate Grievance Office

June 4, 2002

Ms. Grace Zaczek
Office of Primary Care and Rural Health
Maryland Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Ms. Zaczek:

Thank you and the committee for your extensive work resulting in the Task Force Recommendations. My sincere thanks to you and the entire committee for your very important questions, observations and certainly the visits to the Department's facilities.

Your work and your report clearly documented the challenge posed to all of Maryland Government and its citizens as this Department attempts to serve a burgeoning population of uninsured individuals who often possess poor health histories prior to confinement and more often than not need significant health aftercare.

I especially wanted the task force and those reading the report to know of my strong compliments to the Department of Health and Mental Hygiene for its assistance to this Department. Secretary Georges Benjamin, MD and his staff have consistently made themselves available to discuss issues of mutual concern and to advise the Department on meeting several health challenges. There have been frequent leadership meetings and those joint efforts will continue throughout FY 2003, especially as it relates to entitlements, transition planning, and infectious disease control especially as it relates to continued planning for Tuberculosis and Hepatitis C.

A significant aspect briefly touched upon in the report and particularly as it relates to Baltimore City Pre Trial facilities is the scope of clinical service delivery for the continuing and frequent cycle of arrestees and inmates. As a further step in the Task Force's work or future planning, consideration should be given to possible new designs for health care delivery especially to local arrestees in custody and post custody. It is clear that the Department of Public Safety and Correctional Services

cannot hope to address on its own the enormity of health service challenge this population presents. To that end, this Department needs to enhance the state and local health department and others in new types of collaborations to enhance health care service delivery.

Finally, I want to highlight and commend the Social Work Unit of the Department of Public Safety and Correctional Services for their tireless work to provide comprehensive assistance and aftercare planning for a broad scope of inmates. At your hearing this past April, I outlined in broad detail much of the work the social work staff has undertaken to improve health outcomes, assist in transition and assure continuity of services. The Department is deeply indebted to them.

Again, thank you for the opportunity to address the Task Force and please consider this for inclusion as an appendix to your report.

Sincerely,

STUART O. SIMMS
Secretary

SOS/ds

c: Georges Benjamin, M.D., Secretary
Sharon Baucom, M.D., Inmate Health Services
Anthony Swetz, Ph.D., Inmate Health Services
Barbara Boyle, Director, Social Work Unit

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

June 7, 2002

The Honorable Rudolph C. Cane
Chairman
Governor's Taskforce to Study the Health Care Needs of Inmates in Transition from Correctional Institutions
Lowe House Office Building, Room 414
Annapolis MD 21401-1991

Dear Delegate Cane:

Thank you for the conscientious effort your taskforce has devoted to defining the health care needs of newly released inmates as they return to communities in Baltimore City and across Maryland. I appreciate the far-reaching recommendations outlined in your report for helping to ensure a smooth transition for these citizens to specific health care services in their local communities.

Secretary Stuart O. Simms, Department of Public Safety and Correctional Services (DPSCS) and I are creating an interdepartmental workgroup to address your taskforce's recommendations. This joint effort will focus on expanding the already strong collaboration between our departments to meet the health care needs of low income, uninsured citizens as they return to our communities.

I especially want to highlight the extensive work between DPSCS and our department to address care for incarcerated individuals with infectious diseases, particularly Tuberculosis and sexually transmitted diseases. We will work with DPSCS and DHR to examine the process for newly released inmates' participation in entitlement programs. The Department and DPSCS are exploring potential strategies to enhance community primary provider involvement with pre-release care, transitional planning and follow-up care in the community.

I want to commend DPSCS staff on their work to provide pre-release planning and arrange follow-up care for inmates across our State. If you have any questions, please do contact me. I can be reached at 410-767-6505.

Sincerely,

Georges C. Benjamin, M.D.
Secretary

cc: The Honorable Stuart O. Simms

APPENDIX III

TOWNHALL MEETING, JULY 19, 2001

Task Force to Study Health Care Needs of Inmates in

Transition from Correctional Institutions

Town Hall Meeting, July 19, 2001

Introduction of Panel Members by Grace Zaczek:

Delegate Rudolph C. Cane - Chairman

Ms. Grace Zaczek – Director of Primary Care & Rural Health in the Maryland Department of Health and Mental Hygiene

Ms. Michele Douglas – AIDS Administration, Maryland Department of Health and Mental Hygiene

Liza Solomon, Dr. P.H. – Director, AIDS Administration, Maryland Department of Health and Mental Hygiene

Barbara McLean, M.D. – Baltimore County Health Department

Joseph Tetrault, Esq., - PRISM

Anthony Swetz, Jr., Ph.D. – Director of Medical Services for the Maryland Department of Public Safety and Correctional Services

Ms. Malinda Miles – Prisoners Aid – Eastern Shore

Dr. Jessie Thompson - NAACP

Ms. Marion Sjodin – Baltimore City Health Department, Primary Care Office

We owe a special thanks to Ms. Sjodin for arranging use of the War Memorial Building for tonight's meeting.

Delegate Cane:

I'd like to thank everyone for coming out tonight in spite of what has happened on Howard Street. I'm happy that everyone came out.

The State of Maryland is trying to do what I consider a progressive program to benefit all its citizens. One of the things we did this year was to pass this legislation that would allow an ex-offender on felony charges to be a first class citizen again, to be able to vote. That's a great move in the right direction to have a chance to operate in the process of government. I think it was one of the best things has that ever happened.

It was also brought to our attention that there are some problems as far as health care. We figure that one of the things that is necessary for us to bring to the attention of the State of Maryland is maybe we need a program to assist on the discharging of prisoners back into society.

We thought it might be good to have some type of connection with social workers who could work with the offenders and Medicaid - maybe 28 days before the offender is out so they would be eligible to get some assistance. They could arrange transportation back to the areas which offenders are from. If the offender has a substance abuse problem and going back to their same area it would not be a good idea, then we would try to help them there.

But the most important issue is health care needs. Hypertension, Diabetes, Hepatitis, AIDS, all of these things, we want to link you to primary medical care for a smooth transition so you have the resources necessary to experience a better life. It was brought to our attention the best way to do this – we are working on theories and concepts and so forth, but to talk to the people who have gone through it and let them have input on what they think would be good to implement in this program and make recommendations to the Governor.

I hope you consider this a very, very sincere and important townhall meeting and what you give us will be utilized in the report as much as possible so that we can try to make a real change for the betterment of the citizens of the Maryland. Thank you again for coming and I hope that you

will listen to the panel and make any comments that you like that would benefit this report. Thank you again.

Ms. Zaczek: I want to acknowledge Senator Andrew Harris of the Ninth District who is a member of the Task Force who just joined us. I like to introduce Dr. Jessie Thompson, from the NAACP; he has a B.A. Psychology from Benedict College, Columbia, South Carolina, an M.A. in Education and Counseling, from Southwestern University in Fort Worth, Texas and a Ph.D. in Philosophy and Psychology from Dallas Theological Seminary. He is on the Executive Committee and is a Life Member of the NAACP and is also a subscribing member of the NAACP's Golden Heritage. He's currently a science teacher in Special Education with the Baltimore City School System.

Dr. Thompson: One of the problems we are having today is health care, which plays a major role in society today and funding. Since there is such a problem with funding we suggest you contact your Senator with this issue because funding is needed badly for health care for the ex-offender and substance abuser. I want to give some encouragement to the ex-offender to not give up and to stay focused.

I want to give some outline about winning the weight war. There are no percents yet, but The National Black Women Health Project, Walking for Wellness, the Association of Black Cardiologists Initiative, Fitness Initiative is bringing fitness attitude in the black community. (Shreka Tamak) she is the Assistant Dean for Health Promotion Disease Prevention at the University of Pennsylvania. Everyone needs to do something positive like exercising and finding a fitness center to do positive things for our lives. Smoking destroys all of us and if you continue to smoke it will effect your lungs, membranes and everything about you. I encourage you to stay away from cigarette smoking.

According to James D. Hill Ph.D., Director of the Center Human Nutrition at the University of Colorado Health Science Center he said keeping slim is very important. He encourages you to stick to a program and losing weight and keep it off and stay on a low fat healthy diet with exercise. People who have body mass index of 37 and above with diabetes, hypertension, according to Dr. Hill it would be good for you to see a doctor or ask about new treatment. Even if you are not obese it still a good idea to seek a nutritionist or enroll into a weight reduction program. This is very important for you to think about your health & life because you are the only one who can bring you down. You need to feel good about yourself and get involved in some type of weight program. I suggest exercising like jogging, running, walking but I encourage everyone to exercise. I represent the NAACP, the National Association for the Advancement of Colored People. We just left New Orleans and there are a lot of issues that we are facing and we need to stick together and work in unity so we can achieve the goals we need to achieve. I encourage ex-offenders not to focus on your reason for going to prison, but to get up and focus on things like church activities, sports, self help groups and socialize with the community. The NAACP is willing to help any way they can. The telephone number is 410-366-3300. Call anytime for any reason. Teen pregnancy is something that is very important in our society. So that's why we try to talk to young people in our schools, and our meetings to try to have them not engage in this type of activity which we know they shouldn't engage in but if you do, try to use some type of contraception. Thank you very much.

Ms. Zaczek: I'd like to acknowledge Delegate Shirley Nathan-Pulliam who is a member of the taskforce who has just joined us. I want to thank Dr. Thompson for his comments. I would now like to introduce Ms. Malinda Miles. She has her Bachelor's from St. Augustine's College in

History and Government. She pursued a Masters in Education from Howard University and Master's from Antioch School of Law in labor law and equal employment.

Ms. Miles: First of all let me say "Good Afternoon" and thank you for giving me this chance to speak with you. Let me give you a brief summary of what the Prisoner Aid Association of MD is. It was founded in 1869. Some five years ago we wondered if our doors would still be open. Today our doors are open primarily to make sure that the transition back into society by inmates is smoothly done by providing them with services that we believe are important. Of course important to us is housing, employment, counseling, substance abuse treatment, etc. However, equally important is the health issue. We have been very successful over the past years in coming out with the appropriate housing, various liaisons with D.O.C. (Department of Correction) and in the past 3-4 years we work very closely with Baltimore City Health Department. I will talk from the cuff of some of the issues that we are facing. Over the past 5 years, we've had clients coming out of incarceration with three days supply of medication. Some of those clients needed a lot more than three days medication supply. We are told that access to medical services is available, and that medical record is transferred out with them, etc. One of our primary issues is that Yes, they get the three days supply of medication but who makes sure they get to where the health services are for follow-up and the treatment that goes with their illness. What we've been having to do for the past few years when clients come out and they are in crisis is to try to get them to one of the emergency hospital centers. We are talking about clients who sometimes have medical illness or mental illness and that are using psychotropic type drugs. Sometimes those drugs do not carry them far enough. Maybe they are selling them or what we don't know. There is a transition problem that has to be filled. There needs to be some type of help in the health care in reference to that. They say that in the State of

Maryland they can receive a Pharmacy Assistance card and the Pharmacy Assistance card is supposed to allow them to get their medication they need. But it takes 30 to 40 days to get the card and your medication has already run out, what good is the pharmacy card. Through the State of Maryland they can get Medical Assistance, but they are told they don't need it and someone next to them with the same issues receives assistance. There's something wrong with the system and how does my clients get the assistance they need. Often times they are told you have to be employed. This is one of the conditions of release from incarceration. One example is, if you need eyeglasses and have no way of getting the eyeglasses, even something simpler than that a lot of jobs want you to get a physical and the client is not able to afford it and where do they go get it and how do they get the job without it? We are saying there are some real important issues in smooth transition for inmates back into society to make them productive citizens. My organization has talked to and seen clients who have come into our office with no smooth transition to health care with illness. We try to get them into other medical facilities and because they don't have health insurance no one will take them. There are gaps in the health care system when it comes to inmates. We've seen clients with diabetes and thanks to Baltimore City Health Department who have screened and tested them. But what about the ones who have the disease and need treatment? They go to the emergency room for treatment. Then they have medical bills that follows them forever that they can never pay. We're not trying to give you different classes of issues here, but we're saying that the whole medical process, treatment, availability of health care should be for all Marylanders. Especially for ex-offenders and inmates who are coming out of that particular scene. I talk to my female clients and females are a whole different ballgame. They still have issues that the males don't have to deal with and we will refer to it lightly as female problems. It's very difficult to get services when it's just female

problems. How do you get to a doctor to examine it and how do you get something done about it? One of the things that I have discussed and debated with Marion on a few occasions is we have places that will identify it, we have places that even tell you what is out there, but then treatment becomes another issue. We're asking at this forum and the sub-committee that I've have been fortunate enough to work with, to help us find ways to provide health care in a more and basic and substantial way to our population. This past week Marion Sjodin and I were fortunate enough to go to Carroll County to sit down and talk about what are some of the remedies. I've taken the last few minutes and identified some of the problems. There are a few of things we are suggesting or recommending. Inmates know at some point in time they're going to be released so do their supervisors and others that run the institution. For the last few years we've talked about pre-release plans, we are suggesting along with pre-release, have them fill-out the Pharmacy card, have it submitted, have the information back and the Pharmacy card issued at the time they are walking through the door. It's good for 30 days and hopefully with some coordination of the effort between Release, Parole and Probation and the client's Medical assistance that is needed we will have a better coordinated service there. One of the concerns that was raised about having all of this supposed paperwork done by an already over-burdened D. O.C. (Department of Correction) is who is going to do it seeing they are very light staffed. They already have too many people for the staff they have. I recommend training the inmates and allow them to complete and fill-out the Pharmacy application and have them do some of those things that are going to help them to become productive citizens as they walk out that front door. We already have them doing some jobs in there. Let's look at some jobs that will help them while they're leaving.

In addition to looking at getting the Pharmacy card, we're saying that there should be some definite review of, the current Medical Assistance care practice and assessment. There needs to be some serious review of why or how the system can work to better serve not just inmates or ex-offenders. I did a little test in Carroll County to see how difficult it is for someone not labeled as an inmate. It's not easy at all if you have two identical people with same issues and problems going into DSS (Department of Social Services) to get their Medical Assistance Card. One walks out with the card and the other does not. Why?

It's very necessary for validation that the doctor's got to provide all the information etc., but sometimes it appears that there really is no system working at all. We need a review of that. Prisoner's Aid would like to say tonight to Delegate Cane and Delegate Nathan-Pulliam we appreciate this taskforce and for looking at the health care issues and we like to continue to stay involved and to see the outcome of it and we thank you for allowing us to meet with the sub-committee.

Ms. Zaczek: Thank you, Ms. Miles. Our next speaker is Mr. Joe Tetrault, who holds a Bachelor in Art, from St. John's College, in Santa Fe, New Mexico. He has his Juris Doctor Degree with Honors from the University of Maryland School of Law in Baltimore, where he was Associate Editor of the Maryland Law Review. He worked as a law clerk for both the Prisoner Assistance Projects at the Maryland Legal Aid Bureau, and at the Appellate Division of the Maryland Public Defender's Office. He was staff attorney for the Prison Assistance Project. He is currently Chief Staff Counsel for the Prisoner's Rights Information System. He's also a Member of the Bar of the Maryland Court of Appeals, the U.S. District Court for the District of Maryland, and the United States Court of Appeals.

Mr. Tetrault: I'm glad to be here. I'm glad to see all of you. I really don't have a lot to contribute. Unfortunately, our firm represents prisoners only. We really must close the file after the prisoners are released. We can no longer represent people who are released. Some of you may know our work. We had been doing the wave of good conduct credit cases-Hutchinson, Henderson, Fields & Wicks that have resulted in the release of thousands of prisoners in the last couple of years. So, we have to focus on the ones who are incarcerated. These are all very interesting suggestions here. I think we need transitional services to begin at least 3 months before people are released. Unfortunately, I disrupt that because when I get them released, I get them released very quickly with a court order. My release comes as a surprise. I wish this committee good luck with this and if you have any questions I will be more than happy to answer them about what I do. Once again I like to thank you and this is a good program. Thank you very much!

Ms. Raisa Abdul Rahim: I'm glad to be here because I've worked in Division of Corrections for almost 18 years. Thirteen of those years it was my job in the work release program to find employment for persons who were going to be released. It's never an issue or concern if the company affords medical benefits. Most didn't, some did, and probably they were the exception to the rule. I'm now working with a management corporation and I'm still finding jobs for ex-offenders. However, when I'm talking to some of the employers, I'm finding out they believe that if you hire ex-offenders that the State is still providing some type of assistance. This is naive on the part of some of the employers, but some have said to me and it may sound stupid to you, or maybe not stupid, but they are being released from prison aren't they covered and I'm saying they are not. I'm saying there are issues of providing medical benefits and other benefits to employees. I'm here today because of this taskforce and the lady before me who spoke gave

some very good solutions and I really hope that's why we are here today. I would like to see where employers would get tax benefits for offering jobs to ex-offenders with benefits. Often times they are getting tax benefits for offering employment to a person, who lives in a primary zone, to a person who has come out of the prison system. I'm saying let's take it up a notch and help the employers to help the citizen and empower Baltimore not with just some of the citizens, but we have 50 people daily released from the prison system and returned back to Baltimore. There are 80% coming back to Baltimore City. Let's not just empower the economic areas of Baltimore that haven't done well, but let's empower all of our citizens, employers as well as ex-offenders.

Ms. Leslie Lietch, Baltimore City Office of Homeless Services: I'm going to take a little different approach and I do have written testimony that I will distribute after I give my presentation. First, I would like to thank Delegate Cane for giving me the opportunity to have a chance to speak to you. I'm the Director of the Office of Homeless Services for Baltimore City and I oversee the administration of Federal, State and Local funds for providing a continuum of care for those at risk, and who are experiencing homelessness. We have the unfortunate distinction in Baltimore City of being 56.7% of the State's homeless population. On any given night that means we have 3,000 homeless individuals and in a given year that's over 30, 000 people. A recent study on our homeless population shows that 69% are men, 57% are women who have a history of incarceration and their health care needs are staggering. Data coming from Philadelphia indicate that the age-adjusted morality rate on these individuals is 3.5 times higher than the general population. Common reasons for death are injury, heart disease, liver disease, poisoning or over-dose. The homeless often are admitted into acute care hospitals five times more often than the general population and psychiatric hospital one-hundred times more

often. Resources are being thrown at this population, but the cost-effectiveness is terrible. The sheltered homeless utilize the health system more than the unsheltered homeless do. The unsheltered homeless are more likely to use trauma and acute care facilities. If the trauma rates are to be reduced in order to focus on the management of chronic disease, housing arrangements must be met. When asked what are their reasons for not seeking health care when it is needed, the frequent responses were:

a. lack of transportation

b. previous provider asking too many questions but no follow-up.

This raises questions about how health care is delivered. I do have some examples of successful programs. Within our system of emergency shelter providers, we are funding two facilities to house individuals who are in need of convalescent care. These are individuals who were hospitalized but were released with no housing plans, except for 2000 North Broadway which is the local Department of Social Services or Health Care for the Homeless. Sixty-seven women and 196 men were housed in the last year at our convalescent care facilities. Sixty-five were turned away due to their needs for skilled care, which means if they were not in convalescent care or in a hospital, they were on the street. Men stayed an average of 19 days, women 39 days and these are going to be the women who have recently delivered and they get two days in the hospital and now they are on the street with a new-born that's two days old. The most frequent primary diagnoses included dermatological issues, musculosketal and respiratory concerns. Secondary diagnoses are gastrointestinal, psychiatric and cardiovascular issues. These are not issues our shelters are prepared to deal with, nor should they. In 2000, we won competitive awards to provide pre-release case management and transitional counseling for HIV-positive individuals in prison systems. Beginning in April 2000 and so far in 2001, 91 individuals have

been referred to this program out of just four prisons. Fifty-two are participants, and 23 are in prison right now on the pre-release case management.

Many of the clients were diagnosed HIV-positive while in prison and have not dealt with their ongoing issues, or their future issues of ongoing health care, even issues of their disclosure. While there continued to be some systemic issues such as knowing when an inmate is going to be released. Thank you for the services but most challenging is the transfer of his medical records although that has really come a long way back; most of the client's greatest need is drug treatment. In addition to the identification and treatment of Hepatitis C and other STDs, and depression is the big problem. Imagine being a prisoner finding out you are HIV-positive and you can't tell anybody. The incident of depression is over 60%. It is no longer an issue of what we can do, but what we must do. We must provide access to medical services where individuals are, whether in prison, sheltered or unsheltered. We must provide access to appropriate medical services to develop more convalescent care resources and we must provide a seamless transition of medical services as individuals move from prison. I thank you for your concern and attention to these issues. I look forward to helping you as you move toward identifying and implementing effective and more long-term health care solutions. Thank you.

Delegate Cane: It's great to find out all the resources we have and the interest that people have in making sure you have the opportunity to improve your lifestyle.

Mr. Steven Baron, Baltimore Mental Health Systems: Thank you, I appreciate being here. I'm Steven Baron, President of Baltimore Mental Health Systems. We're the local mental health authority for the City. Unfortunately, LA County Jail has become the largest psychiatric facility in the country. I don't know if people know that or if people are aware of that. The New York

Times has written some articles that received a lot of press. Baltimore City Jail probably has 8 to 16% of people with mental illness, State prisons about 16%. We have done a lot of transinstitutionalization and there's been a need to improve our ability to work together on Mental Health Systems and the Department of Corrections around this country. Actually they operate in two different worlds. We need to do a large amount of work to improve that. What's almost kind of nice about this committee, when I think back to some of the earlier days when working with folks coming out of State hospitals in the earliest 80s, there are a number of laws coming out of State of Maryland now that have come out of that process. As Ms. Miles talked about transition and Leslie spoke about transition there's very little and few things more important I think, than to get our systems working together and work on transition in an appropriate manner. In fact, I would ask the committee in hopes they have looked at some of the after-care planning requirements by law of an individual leaving State Psychiatric Hospitals or any psychiatric facilities. Unfortunately, the State does a much better job than the general hospital in discharge planning and after-care planning, but I think there is something to be learned from our transition from community to State hospital, as from prison into the community. I'm going to make about four or five specific recommendations, but before I do that, I just want to point two things out that we are trying to do as the System Manager. We are not a direct service provider. We are the manager of a Public Mental Health System that provides services to the City to about 24,000 people either on Medicaid or uninsured. The services providers-there are various ranges of providers. About 60% of the people are over 18 and about 30% have a serious persistent mental illness. Of the adults and of the children, 90% have serious emotional disturbances. It's a population much in need. There's a whole range of

services. Things are crowded up in other areas that we need to show a great deal of improvement in. There are two initiatives worth pointing out to the committee:

1. One is with Baltimore City Detention Center and actually through the Medical Services of Circuit Court we have Forensic Assistance Services Team that work with both those already incarcerated at BCDC, and then with the court system to try to divert people, support people and link people up with community services. Through a number of situations people been quite successful in that way and also working with folks in the jail, our manpower is not what it needs to be to do that, but it has been an effective model.
2. Second, we started a recent initiative through the Patuxent Institute which is under the Department of Corrections where the community provider works with those in the Patuxent Institute three months prior to discharge and develops service plans and works with coordination. There are some very, very moving stories of people who haven't lived in their community for 20 years going back to their old neighbors and getting re-established into the community. It's a structure that works.

But specifically some of the recommendations we've like to make is that we need to have a more complete need assessment for the mentally ill. The mental health needs of individuals currently incarcerated since we have 8 to 16% with a specific mental health diagnosis that are significant, but only 70% of the services of the State prisons do an assessment. About 70% of the individuals that are incarcerated at BCDC come back to the community immediately, directly from BCDC. That's almost the equivalent of those in acute hospital stays. And working with and creating that coordination is very difficult for me to figure how to do that better. We need to

do organized training of correctional staff to recognize behavioral needs. Just last week on July 15, AP released a story that only 10% of male inmates receive treatment, now if 16% is the need and 10% are being treated, it's not so far off. I really do count, or as Leslie said of the episode of depression, people who are identified as primary substance abusers which is probably about 80% of the people in the jail really have a occurring disorder and serious depression anxiety and post-traumatic stress disorder. We want to insure that treatment begins when the individual is incarcerated, and there are appropriate services to the person while they are incarcerated. We recently found out that BCDC, and it may be the same policy through out the State, that people are not started on medicine until they have a bail review and that could be days and people could be very symptomatic if the medicines is not started. We are also very concerned about people getting medicine when they need medicine. As I said earlier, we need to provide comprehensive discharge planning. This really needs to be worked on and we really need to work on this so we are not pointing fingers at each other, but in a cooperative manner with one another. We have a very much over-taxed Department of Corrections and a very over-stressed mental health system. There has got to be a way to figure this out. We'd like to see incentives for community providers to offer a range of services to individuals released by DOC, not different from the employment incentive. And finally to require State agencies to prioritize populations of individuals with psychiatric disorders and to develop specific plans to address their needs. Thank you, and I will give you written testimony.

Mr. Malcolm Coley, At The Door: As a person, who is actually out there on the front line, I heard everything that was said thus far. It's been my experience At the Door - let me explain real quickly what At the Door is. It's a program developed by HUD (Housing and Urban Development). What it is, we go in 3 to 6 months before an inmate is released and do intensive

case management with the inmate so that they make a smooth transition back into society. So far we have a pretty good success rate. We have about a 50% success rate. The problem we are having now is we are becoming overwhelmed and we only do a specific group, which are HIV-positive clients. That's all we do. The need is much bigger than HIV and as far as connected to medical services-there are a lot of breakdowns. I find that day-to-day in this system if, someone was coming out and they haven't been getting psychological treatment while they was in there, I can't do anything with that client until I get that client out. A lot of the time when I get that client out, it is too late because the client will go wherever. There are four cases I can almost tell you off the top of my head where that has already happened since I been on this project. That's not to say that every project has its bugs. This has its bugs, too. But I think that if we expand this project, it is a step in the right direction because we are a part of the community and we work very closely with the jail and they have been very cooperative with us, also. But to me that is one viable solution to a situation that needs addressing and needs addressing in a hurry. There are a lot of people out there on their deathbed with AIDS, Blood Cancer or something worse. By the time I get them, a lot of them are in need of medical care but if it weren't for us I know a lot of people would not make it. As a matter fact, I asked a few of my clients to come and I think I see one here. I seriously would love for him to come and tell his own personal experience about what it was like getting out and what it was like having that experience. Thank you.

Delegate Shirley Nathan-Pulliam: There are a number of people with HIV and AIDS who are coming out of prison. What percent of those are drug addicts?

Mr. Coley: Ninety-five percent.

Delegate Shirley Nathan-Pulliam: And of the 95%, besides working with them with HIV problems, is there any treatment program that you are able to put them in right away?

Mr. Coley: No, what we do is built into the grant where we have a transition where they come out and go into transitional housing and depending on what is the primary issue in their lives. A lot has substance abuse problems but they may be medically fragile and we put them in a medically fragile house, first before we can start to address the substance abuse problem. Some come and go directly into Recovery House. The problem is a lot of them have never experienced recovery before. They don't understand the whole mechanic of recovery, the mechanic of goal setting, and the whole thing-none of them really get that. Then by the time we get them out, we do a good job and we have a buddies system. This is part of the program where former inmates who have went through the process become buddies to inmates coming out and help them with the process when they come out which goes back to what you were saying-train some of the inmates. Yes, 95% of them are drug addicts and identify themselves as drug addicts and they have a history of drugs they need help with.

Delegate Cane: We hope to have questions and answers after everyone has spoken so we can hear from everyone.

Mr. Gary Parker: First and foremost I like to thank you, my God and the Board for having me here and for letting me speak. When I found I had HIV it was two days before leaving prison. They just sent me out of prison on the street. I came out and I went right back to prison because I did not want to spread the disease, I did not want to deal with society. I didn't know whom to tell and did not know anything about the disease. Then, when I return to prison on September 13, 1999 for accessory to assault, I know then that I did not want to get high anymore and needed

to take care of my disease. I went out there and I got it and I always blame God for giving it to me, but I went out there and got it and to face up to my problem by saying I went out there I had unprotected sex. However, I got it, I have to live and deal with it, but if you want to make my disease your problem, thank you for taking my problem away from me. The second time I went into Baltimore City, Jail my blood count was going down and they put me on medication immediately. City Jail took very good care of me taking my medication and I would like to commend them for that. I went to DOC lab the other day and was told they don't have my medical file and we don't have your medication. I had to go for months without my medication and I was told not to go so many months without my medication. Right now I'm on low blood count medication and I want to stay on it because it will help me to bring my count up so I can live a longer life. Every time you go from one jail to another, it's the same process that you can not get your medication right away and they act like they don't care. For everybody that's in a correction facility and have to take medication or see the doctor, they have to keep paying $2.00 to see the doctor and we don't have any money. Anyway, I met with an "At The Door" counselor and that was the first visitor I had in my whole life in jail. When the "At The Door" counselor came to see me. It gave me hope and that's were I'm at today, I'm working and doing well. They also gave me the application to go down to DSS and they turn me down to receiving money or food stamps. So I tried to get Medical Assistance. They turn me down. I said I'm HIV positive. Thank God for Ryan White. I do not know who Ryan White was. I always hear about him and I saw him on TV. But right now, thank God for Ryan White. I'm glad God took him off this earth when He did and He has things open for me because of that I'm living right now and today my medication is coming through Ryan White. Everything that is happening for me is through Ryan White Funds. DSS turn me down for Medical Assistance and I'm HIV.

When I first went to Baltimore City Jail my blood count was 273 and now it's back up to 5 thank God to the Man above and I take my medication. It's going up. One thing that DSS did when they turn me down for everything they taught me I have to live on my own, so I went and got a job. A Narcotic Anonymous meeting I spoke about my disease. The program that "At the Door" has me in, I went to Recovery of Health and the Recovery of Health help me to become drug free. Don't applaud me. Applaud God. I've never talk to anyone sober in my whole life and to be here talking at a town hall meeting, I don't know what to say. I ask God to give me the strength, words and the knowledge so what I'm saying is through God. The Recovery House is O.K., but they only give you 90 days, and after 90 days you is back on the street and between working and that you will be back in prison or back to using. We already have things we have to work with things, but they keep saying they is going to get us a house, they be saying they're going to do this and that I'm keeping it real. After 90 days there, I have to leave. I think it should be more extended time, I think they should have a whole separate program when we come to newly released inmates. I saying this because we have habits. I'm an addict and always going be an addict and that I have a disease and I'm going to die with this disease, but I'm going to die sober, clean and proud. I'm going to do something with my life because God has something in store for me and I know He got something in store for me. Someone told me today that no matter what hole you are in, I know God will find a way out for me and justice is going on in my life. Then they close the Prison Aid for ladies. A lady in there that had HIV, she went back to using. I ask her what are you doing and she said, " I'm using," and I said "Oh God, why you using", she said they close the Prison Aid up and just throw them out on the street. We really need help for homelessness, Prison Aid, please, please, please, and Ryan White Funds is getting ready to run out. Then what is it I'm going to do? I'm working and I'm not getting paid a lot of money. I'm

just working to be a productive citizen in society because I have to right now. I want to work for things in my life. I never even fill out an application in my life and I don't know how. When they ask me about skills and I said what you want me for-stealing, robbery? Is that a skill? That's the only thing I know to put on the application. But through Narcotic Anonymous, a gentleman heard me speak and he asked for my number and he call me. I started working at a labor mason company. I was working in the air and I was carrying mud and bricks. I ask God Are You sure this where You want me to be at? I'm all the way up in the air and I'm still asking God. Is this were you want me to be at? I right then I realize, He work through people to get to me. And when I realize this is I feel-His church, and I'm doing His work but I'm getting paid now for doing His work. I like my job and getting better at it. But I'm asking you to please look at giving us a long term and a little more time at recovery houses for everyone who come out of prison. We need a little more time. Ninety days is just not enough.

Delegate Cane: Your testimony was great, however some of us have a great distance to travel down. I have a couple of hours to travel. We would like testimony to be 5 minutes so that the panel has a chance to ask you some pertinent questions that we can document in our report so that we can be meaningful when we present it to the Governor.

Mr. John Bunting, Chairman, The Baltimore City Commission On AIDS: Thank you for convening this taskforce, and thank you for having me to be here to respond for the Commission on AIDS. I don't come here to provide testimony, but I did come here to listen and to learn. I'm overwhelmed at some of the testimony that has been brought forward. Apparently we all have a lot to learn about this transitional community. Our Commission on AIDS is just forming and we'd like very much to work with this taskforce and talk to some of you as to what we can do together. We need your support, we need your input and we need your help. We also need the

help of everybody else in this room, I can only imagine the barriers the people who are in the transition community must face. I know a lot about barriers from the last 20 years. People face HIV and AIDS. Just imagine if you can, and I know I'm speaking to the choir. I realize additional barriers people transitioning back into the community must be facing. That's a whole new dimension that I think we need to address and all of them. Whatever our commission can do to assist in that regard, to try to help find out what the needs are to guide the program and recommend to the City Council here in Baltimore City. That is our mandate and that is what we are going to do. Baltimore City-I say to the taskforce-we are very much aware of what the impact of the transition community out of the correctional institute has on our City. It's a monumental need. Thank you for providing us opportunity to work with you. Everybody on the panel and everybody in this audience, please know you are invited to our Commission Meeting. The next one will be next Wednesday from 1 to 3 and that will be the Episcopal Diocese Building at North Charles and University Parkway. We invite you to come, we invite you to give us your experience so that we can help to provide the plan and recommend that to Baltimore City Council. Thank you very much.

Ms. Nicole Kennedy, Health Care for the Homeless: Hi – Thanks for allowing me to speak on a few things. Let me give you a little background for those who don't know about the Health Care for Homeless. I work for a primary medical clinic that will provide addictions, mental health, medical and social services and I'm a social worker there. This is an issue that really struck me and I get a lot of e-mail all the time about taskforces wanting to get information that affects our clients but this really caught my attention. I heard a lot of information this evening and Ms. Miles and a couple of other people mention something I was going to talk about-lack of access,

medical assistance and pharmacy assistance. I can go into housing, employment and how incarceration can affect access to those important resources and how it all comes back to health. With not a lot of time, there are a couple of things I would like to make sure to mention this evening. The first thing I notice no one mentioned when a person is first incarcerated their identification is taken away from them and they don't get it back. Also their medication. Being a person on the other side I work so hard to help my clients to get access to very important things if they are going to get anywhere. It's very tiresome, very upsetting to a person to see them taken away. Especially medication that is very expensive and talking about HIV, it is very important for HIV patients to have their medication. Especially if a person is taking them for a long period of time and stops taking them they can get even sicker than when they started taking them. So it's very important that this is addressed. The second thing that I mentioned earlier, the FAST Program is an excellent, excellent resource for people like me who try to advocate for people within the court system who don't know a lot about it but and are still learning. However having those educated people help me and my clients make sure especially there is some method so their ailment is addressed in the court system. Then when they are released, having someone- an agent who they report to who is educated about mental illness or about other illness that they are encountering. It's an amazing resource. We need some funding for the FAST program. Otherwise, I will be around for questions. Thank you.

Delegate Cane: From the ARC – Anne Arundel County-Kathleen Flahive.

Ms. Kathleen Flahive, ARC-Anne Arundel County: Good evening I really want to thank you for the opportunity for being here this evening. I'm the director of the Advocacy Community Outreach for ARC located in Anne Arundel Co. For any one who are not familiar with the ARC- we provide a service of support and advocacy for individuals who have mental retardation and

other developmental disability. We now know that in the general population that about 3% of adults have mental retardation. However, we don't know how many inmates in Maryland have mental retardation. We do know that among the inmate populations nationally, there are many studies that show there is a disproportion of numbers or higher number of individuals who have developmental disability. We know that we are looking at more than 3% of our inmate population in Maryland has significant common disabilities. We were approached by staff members at Jessup to come in and talk about the problem. And we were told that there is no system to identify inmates who might have mental retardation or other disability. Also, there is no data that really let us know how significant this problem is. There is no coordinating effort to refer people to the service support that they will need when they are released. We are very, very concerned about this, as you hear about all the challenges, limitations and difficulty in access in all the needed health services. How hard that it is people are released from prison and imagine the impact of having a constant disability on top of that. We have people in the community who have mental retardation and have a increasingly difficult time in accessing health care services and social services because of their disability and we know this is compounded with inmates leaving the prison system. As an advocacy organization, we just want tonight to bring this to your attention. This is not something we hear or read too much about. Many states are beginning to realize that this is a very significant problem and one that needs to be addressed and looked at, and that there needs to be linkages, research, services available for people with mental disability and leaving the prison system and how does that linkage occur? How do we make sure that adults who are leaving the prison system who have developmental disability are being linked to the community resources? What are the services being provided through the State of Maryland's Developmental Disability Administration? I just want to be thankful for this

opportunity to at least draw this to your attention and this problem and I like to thank the taskforce and for having this hearing.

Delegate Cane: I'm surprised to see a colleague of my come in. She's a giant to the Baltimore City Area-Delegate Marriott.

Delegate Salima S. Marriott: Good evening everyone, I would have been here earlier but we had a very important redistricting meeting at City Hall. I just spent some time over there. What I want to do is first off, is to make it very clear that the work of this taskforce for the Health Needs of Newly Released Inmates is extremely, extremely valuable. However, the needs of Newly Released Inmates transcend all of you probably have heard tonight. However to establish a more comprehensive approach, I have employed in the Maryland Senate, Senator Harris. The most aggressive approaches are to correct the problems with the system implementing criminal law. My appeal to you is that you continue the work that you are doing and you recognize that this must to be a realistic approach. And that you do recommend that this taskforce be extended and that vou are able to broaden your mission to deal with the needs of Newly Released Inmates. That would be a recommendation to continue as you're currently doing, I don't know how you can do it, but anyone in this building would come. I think here in Maryland we have one institution-Sinai Hospital that everybody is familiar with. They are now recognized in the community-that they provide services to. They have to be involved with the development of that community. I'm very much aware of this because that's where I live and you probably never heard of a hospital before sponsoring an effort for community economical development. That's because they understand that health care needs are not in isolation. I just wanted to make a few remarks to you about the holistic needs of Newly Released Inmates and I apologize that some of the things I'm about to say have already been said, but I'm going to say them. The increasing

rates of incarceration is something of a broader need of released inmates returning to their community with their still concerns about them achieving respectable transition. Maryland is the 12th highest incarceration rate in the country. That's more than 23,000 individuals within the state prison system and in recent years has released 13,500 each year. There are 27 county jails with the capacity of 10,500. The Baltimore City Detention Center has an average stay of 3.4 months and admits 250 inmates each day and releases 43,000 individuals per year. Ninety-percent of all inmates will have been released back into the community and so I can not say more emphatically. But release is a reality. Not only do their numbers present an unprecedented challenge to the supporting Social Services, without well-integrated transition services those numbers pose a very serious public safety threat. So all of us who are advocates for meeting the transitional needs of Newly Released Inmates-we must frame it as a public safety issue. Anyone, who doesn't respond to it in government, we must identify them as a threat to public safety. It is really about reintegrating people in our community and if we don't do it and in a community that I live in-Park Heights where the crime rates is extremely high. I know that is a major threat on public safety. Not the laws we are implementing. It is how do we address reintegrating of people being released and I have just given you a number that we will release. As we got tough on crime and war on drugs skyrocketed over the past 20 years, so has incarceration and pre-sentencing. We have failed to seriously address the return of ex-offenders in the community. There seems to be an assumption that-incarceration provides opportunity for rehabilitation and regulation. This absolutely is not the case with most individuals returning. When education, training and opportunity for work exists there is not enough coordination or bridging from the institute to the community where individuals will return. There is a turn pike from addressing more basic needs to educational services to incarcerated individuals. Maryland law mandates

school for inmates who don't have a high school diploma and have at least 18 months to serve. Federal laws require special educational services for those who are determined eligible. During FY 2000 - 19, 800 inmates were eligible for State and Federal mandated education but only ½ of them received it. In fact, it was less than that, two thousand one hundred forty-four inmates were on the waiting list as of September 15, 2000. The Secretary of Education, whom we call Superintendent of Education in Maryland, recommended to the Governor the monies that were needed to fill this the education gap. The Governor did not include it in his budget and we from the Baltimore City Delegation requested and advocated for that to be included. It still was not included in the supplemental budget. Research has shown a 19% drop in recidivism for Maryland inmates who participated in education programs when incarcerated. Research also shows transitional services lead to a probable reduction of recidivism. Maryland has two resources of transitional services and I don't want to speak about the health needs because I'm very conscious of that, but I want to go over it because I know that has been well documented. The purpose that I'm expressing here to you tonight is that we move comprehensively. I think that this is probably the first time in the State of Maryland that there has been any taskforce specifically dealing with the inmates needs. I just want to appeal to you that in your final recommendation to expand the role that this taskforce is currently focused on. I don't want to be too much off of the agenda and so I will just close and hopefully I'm depending on you to advocate for all the needs of the current inmates in this community. Thank you very much.

Delegate Cane: One of our committee members or taskforce members has to leave because they're having a redistricting meeting that will impact on her reelection, so I'm going to give her a couple of minutes before she leaves.

Delegate Nathan-Pulliam: Good evening, I really hate that I have to leave for a minute. I'm really going to try to get back. But, the redistricting meeting that is going on that Delegate Marriott just came from. It's really important that I go over there to make sure I can vote, so I can give myself a good chance that I can still be here in the legislature to represent you on this issue. I'm a registered nurse by profession and I got very passionately involved in the health care needs of inmates. The numbers of letters I receive daily from inmates about their health care needs. The number of letter from inmates with HIV, drug treatment, strokes, renal disease-you name it-every disease that you can image. I receive those letters from many who have multiple diseases and so because I'm running out it doesn't mean I don't hear. I heard Gary, Mr. Parker you spoke very elegantly and you touched me in terms of the needs we will have to also hear and work very hard to make sure that people like yourself and others coming out will get the care they need. I know the Senator sitting there-he hears what is happening and we need the compassionate understanding in all the members of the legislature. To sure we make a difference and so I will try to get back before you finish. Thank you.

Delegate Cane: Are there any questions from the panel? Senator, you can join us if you like but please free to ask the audience any question that you would like have cleared up. I'm familiar with the institute that's close to where I live, but I want to ask a general question. Those people who been released from prison-have you ever had less than 2 days medication given to you when you leave? That's question one.

Mr. Coley: I recently had three clients released with no medication at all-one from Hagerstown and the other from MTC with no medication.

Delegate Cane: Next question-do you get transportation?

Ms. Barbara Jones: I was released June 29 from Patuxent Institute and when I was released they did give me a blister pack of medication for my liver because I have a real bad case of cirrhosis of the liver from drinking so badly. However, all my medication is gone now and I have to take it the rest of my life. I don't know any way of getting my new medication and I'm just about out of all of them.

Delegate Cane: I can understand you might be out but when you left did you get any?

Ms. Jones: Yes I got some!

Delegate Cane: How much did you get. How long did it last?

Ms. Jones: I got seven blistered packs and it lasted a month and I used all of them. Thank you.

Delegate Cane: How about transportation?

Ms. Jones: I want to address that issue, too. Ms. Karen has several places she wants me to go.

Delegate Cane: I mean transportation from the detention center or prison back to where you were a resident.

Ms. Jones: No, Sir. No.

Mr. Parker: You have to work in prison and buy a bus pass. And they will take you there, but you have to buy a bus pass.

Delegate Cane: Do they give you the money?

Mr. Parker: No. This is money you earn $40.00 to leave with and then from Hagerstown, you will be broke. They hold the $40.00 in our account which collects interest for how long you is in there. All I get is the $40.00 at the door and all that adds up to a buck. All I'm saying after you get home you is broke.

Mr. Tetrault: Delegate Cane, let me add to that. It's a reserve account and Mr. Parker is correct. The prisoner earns it his first couple of months' pay more than that, actually. So it goes directly

into that reserve account and the prisoner can not spend it because it is called Gate Money. It's $45.00 now. It used to only be $25.00. The prisoner can not spend it. It is an interest bearing account. I believe D.O.C. collects the interest. The money becomes available to the prisoner once he's released and like Mr. Parker said; It's a one trip to Greyhound from Hagerstown or ECI to Baltimore.

Aaron Barnett from Prisoner Aid: We have a lot of inmates come to the facilities and once they receive the money that is in their account, and once they receive this money they are given transportation back to the designation from which they originated. A lot of inmates were incarcerated in certain counties, and they sent back to their point of origin, and not to place where they live. Because a lot of clients that come to us for crimes committed in other places that they were sent to as a result of being sent home. I don't know why this is happening, but we have several clients in past several months through Prisoner Aid that are trying to get to Upper Marlboro, P.G. Co. but instead they're being dropped off in Baltimore City. That might be an issue that needs to be addressed as well as the transportation. You talk about that what is going on with their reserve account. That is what they're doing when a inmate who is working, and if you don't have a job there is no money. A lot of inmates that are in prison are not getting institutional jobs because they're on the waiting list for jobs. However, if they don't have any outside resources sending funds to them, they don't have anything in their account so they don't have any resources so they're looking, they're crying out, they have a need to rebuild as well.

Delegate Cane: O.K. Thank you very much. Any other members of the panel would like to ask a question?

Senator Andrew P. Harris: Hi! I have to go to a community meeting in-town. I would just like to comment that this has been my first time I'm able to meet with the taskforce. I work at Johns

Hopkins. I'm a physician across town and I'd like to thank you for coming out and testifying. The bottom line as the Delegate said is the transition is the responsibility of the State. We're the ones that take people put them in prison-who become your family, your employer, whatever you want to call it. The people that take care of you, and part of taking care really should become a transition. If we don't solve the problem of transition, we are not going to solve the problem that got you into prison in the first place. Then to hear about 3 days of medication, Come on! The worst health care plan you can get gives you 30 days of medication, that's the worst health care plan anybody can give you. That just should not be. The day that you leave-My gosh, you should do the least what the worst health care plan does. Really, that's the truth. Thank you for everyone coming and letting us know what has to be done, I'm one who can communicate back to the Senate.

Delegate Cane: I like to say to you-We will be having a meeting at the Eastern Shore.

Senator Harris: If I can get out of the hospital, I will I look forward to seeing you there. Thank you very much and Good night.

Unknown Speaker: I'd like to ask my new friend Dr. Swetz to share with us any plans that you know of to start the transition process prior to release date-backing up 30, 60 or 90 days to implement some of the suggestions. Are there any plans to do that?

Dr. Swetz: I've been told I have a big mouth, so I don't need the microphone. One of things I can assure you that is of the highest priority of Secretary Stuart Simms is the initiation of transition activities, particularly in the Baltimore Metropolitan area. As you all are probably aware, for the ones who been inside, we moved the Pen down to Jessup. It's now called the Annex and that whole complex in Baltimore City has been reconsolidated and all the facilities in Baltimore City, BCC, BPRU, MPC, the new 500 Break Unit there. That whole complex is

dedicated to and it's called the Maryland Transition Center and it's under one manager. There are a number of initiatives that we partner with. This is real different for us. As you know, when you come into prison you leave the community. For those of us who work there, even if we worked in the community before as health care providers, when we go to work in prison we leave the community, too. There are a number of things about government that make it very difficult for us to provide seamless care. You can't get a Medical Assistance card until you get out of jail and you go to a DSS office and start the application process. Our medical contract requires that our medical contractor provide you, if you have a chronic, serious illness with a 30 days supply of medication. In those instances where it doesn't happen, if I know about it, I can redirect the contract and the contractor can make that happen. There are a number of things that we have done with a lot of assistance from sister agencies like the Department of Health and Mental Hygiene (DHMH), Dr. Solomon, Baltimore City Health Department, and Dr. Beilenson. We have made inroads and have some model programs for the treatment of people with HIV, where we have made a agreement with Department of Human Resources where we can apply for entitlement that can start on the day you are released so you don't have to go to a office and wait. The focus on HIV in this country has really provided our ability to work across that boundary with agencies in the community. One of the things the Secretary and I strongly support and that I advocate is you can't separate Public Health and Public Safety. We have more addicts in the City of Baltimore than any other City in United States. Forty percent of those addicts have a co-occurring mental illness. Many of those addicts-14% are female and 7% are male, are HIV infected. You know from your own experience on the street, when you are ripping and running and you start in middle school by time you are 40 or 50 years old, you have a lot of health care problems like diabetes, hypertension, kidney disease. Those processes really take a toll on your

health care. We are finding at the Baltimore City Booking Center where we take in 95,000 persons directly off the street folks that are coming to us are sicker then they ever have been before. We have many people-16% of the people in Baltimore City do no have access to health care because they don't have access to health care insurance. Another 16% of people have health care plans, but are so poor they don't provide the services that they need that are adequate to their health. The average number of times that the same person comes into the facility is 3 ½ times a year. Why? Because there aren't any support services within the community. Between the Public Health, and ourselves we run a revolving door where, because the resources are not in the community to support you. The only thing we got is a struggle and recidivism and it's a revolving door. We're committed; I'm committed to develop a Public Health-Public Safety Partnership. I agree with Delegate Marriott this not only a health care issue. This is a transitional issue that impacts on housing, education and employment. These are things we need to address as well. We have been able to make a minor impact and kick out very specific projects where we've been able to create a partnership between ourselves and the community and to show some success in some ways. I'm not going to sit here and defend or apologize for our system. We've got 27,000 men and women locked up in the State of Maryland. As you all know, you can transfer from facility to facility. We don't have enough funds for computer systems so we can push a button and the same medical information comes up at MCIH as you have over at Roxbury or the House of Correction. So we need the infrastructure to be able to communicate, so we don't have to depend on a piece of paper that a correction officer loses on a bus or doesn't get to an office. Those are the things that create a serious problem in terms of managing care and we spoke very eloquently on that. We have 45 social workers. We release 13,500 people a year. The work week and number hours that all of us who work 40 hrs. a week-

if you have 2,080 hrs a year. If I go to work and work 40 hrs. then I'm going to work 2,080 hrs. a year. Our social workers do transitional planning. Thirty-five social workers and 13,500 people being released – can't do it. That's about 3,000 inmates that they would have to sit down and do a transitional plan for. One person can't plan for 3,000 people being released. We are tremendously under-funded and stretched. I've been invited by Mr. Bunting to join the Baltimore City Commission on AIDS. I plan to do that and I just want to thank you and I really appreciate the courage that it takes to come here and tell it like it is. Because sometimes in government we have this silence. One agency doesn't talk to another agency. I think there is a lot this taskforce can do legislatively to look at the health general article, to take at a look at some of those kinds of things to break down the barriers of government. We shouldn't have to wait to apply for entitlement after you get on the street. We do need to set up a program. Once again, Secretary Simms and I are very committed to support the taskforce and its work to make that happen. Thank you.

Mr. Parker: You said there seems to be a problem with medical files and everything, but I'm saying medical files-they should follow us, but they can get lost like that, but our records and our timesheets don't get lost. Do you understand what I'm saying? Let's keep it real. My medical files-I thought they were supposed to follow you. You are not supposed to-they should not leave jail without the appropriate medical files. Don't send me out without my medical files. I'm never going back you don't have to worry about me, you don't have to worry about me no more. I'm saying for the guys that is in, their medical files should follow them and should be in sealed envelopes.

Dr.Swetz: I understand, and you know there is a nurse who is going to sit on the third shift. She is going to nod out because we have a shortage of nurses. She's working her second shift and

that file's going to sit there and it's not going to be reviewed and it's not going to be passed. Our commitment file, we pay you guys big bucks if we retain you longer and frankly in any system, we're going pay attention to the things that are at highest risk. O.K. and we need to make health care more of a priority in our system.

Mr. Parker: I think you should get a better contract with someone. You got nurses that sit there nodding out and you know they nodding out. I think something should be done about that.

Mr. Kenneth Shaw: I'm one of the participants in Prisoner's Aid program. The issue I'd like to address is in the correctional system. You have what they call charging you for going to sick call. I have a fee attached to me, even if I don't have money in my account when the money do come into my account, the money will automatically be deducted from my account for how many sick calls I have made. Now what do I do is sacrifice soap to take care of my personal hygiene needs or take care of my health and mental needs. I was released I was running around in the street but due to lack of bed space I found myself on park benches. I was diagnosed with schizophrenia. Meanwhile, I have to wait 30 to 60 days before I can get medication and mean-while the shelter doors are being shut to me. I don't have anywhere to go. I think the issue should be addressed to stop taxing us, stop charging for medical expenses at the D.O.C. level. At the time I have it, we will address that issue right then, and if not we make some type of arrangement once I'm released. Let's make a plan so that I can go to some type of transitional housing or facility. Once my medication is out of my system for 30 days it becomes dangerous for me to put something back into my body again. Because my system has built up an immune system to it. I wish you would address this issue. Thank you very much.

Mr. Lawrence Calvin: I'm presently a client of Prisoner's Aid and I have renal disease. I was released from prison on April 14. I've been in Prisoner's Aid since April 14. I was diagnosed

with renal disease in May and Prisoner's Aid was not set up to handle clients with this type of disease. I'm on the kidney machine three times a week, but Prisoner's Aid reached out for me and made it possible for me to have somewhere to stay and I can grow stronger, stronger day by day. I'm doing just fine. I had problems with my Medical Assistance card because when I went to the pharmacy to get my medicine, I had to pay for it myself.

Delegate Cane: Sir, I would like to share with you if you were diagnosed with renal failure, you should be approved for Social Services immediately and also SSI (Supplemental Security Income) immediately.

Mr. Lawrence Calvin: I've worked with the DEP Application Disability and I had to go to DEP so I could get the services I needed immediately. I had went to Social Services. I would have been there for months because when I had came out of prison I had put in for food stamps. I was supposed to have gotten the food stamps on the 10th, it took 20 days for me to get the food stamps. Social Services have a very poor system and unprofessional. I would just like to thank Prisoner's Aid for being there for me.

Delegate Cane: Are there any other comments from the audience? Are any other comments from the panel?

Ms. Miles: Good afternoon again. What I would like to do for two minutes is say the folks on my right that came with us are from Prisoner's Aid. What we have done with them is to state some of our issues and what some of our concerns are. It seems very easy to say that they are eligible for services at DSS, they are eligible services at HERO or whatever. As part of our case management plan, immediately upon release and entering our services they are told you need to apply for DSS, you need to apply for Disability, and you need to apply YQRL. Have you ever done it and seen how long it takes? Have you gone to DSS and filled out all those forms and be

told it was lost, you need to do it over. Have you ever gone and filled out those forms-not exactly what you needed to do and find out you are not eligible, you need a hearing. They do know and we do tell them, but there is something-there's a flaw in the process and I'm not saying it is strictly limited to inmates or ex-offenders. There's a problem in the process with Medical Assistance, the processes, how to do it, how to address it, how to get it, how to use it. If we say on one hand they have substance abuse issues, one of the things I discovered and I've been in this business for five years is something called short-term memory. And they do have it, so we are asking them to do something that is absolutely impossible and they are going into a system that makes it worse. We need to look at that as an issue. And I would just like to thank my folks for being brave enough to stand up here and tell you about it.

Ms. Miles: It is my recollection that they are not eligible for a lot of services.

Unknown Speaker: Your recollection is fabulous. They're not eligible for a lot of services at DSS. They're not eligible in the City of Baltimore to automatically go on the Social Services listing to get housing. One of the things I was told by Danny Henson and if I'm incorrect, I got it incorrect there, because of some past history on housing, they can't just come out and get a Section 8 and be eligible. There's a five-year waiting period. They're gone, they tested the system, and they tested trying to get housing. We have one woman and I won't call her name, but she has two children, she applied for Section 8 every year since 1996 and she currently is not eligible for Section 8 housing. There are some issues out there.

Unknown speaker: If you were convicted of drugs, was a drug dealer, or had any dealing with drugs you will not be eligible for public housing.

Unknown Speaker: That's true and that's one of the issues that when they come out of there. But another part of that is not only will you not get the services from Social Services. Private

owners don't have to let you come back, so you really get caught between a two-edged sword. You can't get public assistance or public housing and private owners don't have to let you rent their property. Thank you.

Liza Solomon, Dr. P.H.: I like to thank everyone that testified and provided us with information. I'm Liza Solomon from the AIDS Administration and one thing that is very helpful about these town meetings is that they help us realize what we need to do more and do things differently. One of the things we try to do and the issue has come up a few times, and Dr. Swetz talks about it, is to create a program to allow people to have access to our Maryland AIDS Drugs Assistance Program immediately upon release, with no waiting period. So the day you get out is the day your card is available. You get your card; you can take it to the pharmacy and at the same time while you are waiting for entitlements. What I'm interested in is, have you heard of people or have you heard of experiences where people had difficulty with that, or been able to use it and it's been helpful.

Unknown speaker: I was incarcerated because I was selling drugs and along the period of time I was selling drugs I basically started using drugs. I was in there for about three years and when I was born I couldn't hear out of my right ear. So when I was in there I got an ear infection. It just keep running, running, and every time I went to the doctor they would give me antibiotic. It would stop for maybe a day or two and it didn't work, so when I got out I went to Prisoner's Aid and thanks to Eric Bennett he introduce me to HCH which is Health Care for the Homeless. I was there. I saw the doctor and they gave me antibiotic and they worked and I'm also in a program for substance abuse and it works, but I'm three years clean anyway, and I have no intentions of going back into the drug world or jail. I'm proud of myself, really.

Liza Solomon, Dr. P.H.: I think as we continue to do hearings we will continue looking, but there clearly are huge gaps. And the one we can try to fill at AIDS Administration is the one with drugs with HIV. We try to put together models and working in partnership with the D.O.C, also other providers where again there is no waiting list. Once again, the day you get out is the day you get your card and you can start using your card. We want to also pass the word so everyone knows it's available and find out is there anything we need do to change it or to broaden the program to make sure it is available.

Delegate Cane: Sir, you haven't stated anything and I don't want to cut you off.

Kevin Williams: Good evening. My name is Kevin Williams; I'm a client of Prisoner's Aid. I love the issue that you are talking about. The issue has affected me. Imagine being told your release date, but you're homeless and further more, you're unemployed and you got no one to ask for assistance. You have no medical insurance and then I was diagnosed in prison with Hepatitis and the only information I got about it was you have Hepatitis, go get it treated when you get home. So come home with all that and the only place that accepted me was Prisoner's Aid and prior to being released instead of setting up a home treatment plan, he gave me pain medicine. I know my release date was coming, so I had written every treatment center except Prisoner's Aid previous to being released. They set up a home for me, they will also get me a treatment plan. Prisoner's Aid set up a treatment plan that works for me. They also get involved with you and they help you. When you are released you won't be homeless and you won't have issues so that your transition backs into society. The same society that turn their back on you. I can understand that but if we are trying to start over, I'm not asking for a whole lot but I know what I need to do. Could you help to make these things more of an opportunity?

Delegate Cane: I believe what I heard here tonight is, there's something that will work. Let's use it and I think that we are going to try to get as much information as we can on Prisoner's Aid so that with other information that we are getting and see if we can make some recommendations to the State of MD that would be beneficial for all citizens. I will allow you to speak, and then we are going to have to close.

Ms. Michelle Thompson: My name is Michelle Thompson I have full-blown AIDS. I'm currently homeless and I'm trying to get up on my feet and do what is best for me and my kids. I

was wondering could you make available shelters for people with kids who have HIV or AIDS. Thank you.

Delegate Cane: I want to thank everyone for coming. This has been very educational for us and you have given us good information that we can utilize in trying to help the State of MD to help the citizens. So thank you for coming.

Testimony before the Maryland Task Force to Study the Health Care Needs of Inmates in Transition from Correctional Institutions

submitted by Aurie Hall, Program Officer
Criminal Justice Program
Open Society Institute – Baltimore
July 19, 2001

Good evening. My name is Aurie Hall. I am the Program Officer for the Criminal Justice Program of the Open Society Institute – Baltimore. The Open Society Institute is a foundation created and funded by George Soros, an international financier. The foundation operates in over 30 foreign countries and in the United States. Baltimore is the only U.S. field office of the foundation, which is headquartered in New York City.

The goal of the Open Society Institute is to encourage the development of civil society in America and around the world. Because we believe it is important for every member to participate in society, the Open Society Institute – Baltimore focuses our criminal justice funding on the successful reintegration of ex-offenders into the community. Successful reintegration is also in the public interest because if ex-offenders have the means to support themselves, they are less likely to return to criminal activity. Once people have paid their required debt to society, we should help them return to their communities and engage in the civic and economic life of the community in a productive manner. The ability to access necessary health care is critical to becoming a productive member of society. We all lose if we create a shadow society of people who are denied basic needs because they have been incarcerated.

Health and Mental Health Care Needs of Newly Released Inmates

Health care and mental health care are basic needs that must be addressed as people are released from prison or jail. Unfortunately, the incarcerated population suffers from higher rates of health problems, including hypertension, diabetes, HIV/AIDS, sexually transmitted diseases, tuberculosis, drug addiction, and mental illness than the population at large. Many of these health problems occur at higher rates due to years of living in poverty, which results in inadequate diet and lack of access to appropriate medical treatment. Many of these medical problems also represent significant public health problems, and therefore everyone in the community has a stake in insuring that people receive adequate treatment, both before and after their release from prison.

In general, the correctional system currently does not provide standard discharge planning services to inmates. Medical staff do not conduct exit interviews to insure that prisoners understand the nature of their medical

problems and the treatment regimen they need to pursue upon their release. Prisoners are not given referrals to medical treatment facilities in the communities where they are returning and are not provided copies of their medical records. This practice makes it extremely difficult for ex-prisoners to access health care providers in the community, because they do not have critical information about their current medical condition or treatment.

There is little coordination between corrections and the agencies that provide drug addiction treatment and mental health treatment. Prisoners suffer from both drug addiction and mental illness at much higher rates than the general public and both of these conditions, if left untreated, can have a significant adverse impact on public health and public safety.

We recommend that the Department of Public Safety and Correctional Services insure that medical staff in correctional facilities conduct adequate discharge planning with patients prior to their release from prison and jail. When medical services are provided through contracted vendors, a requirement to conduct appropriate discharge planning should be included in their contract. Medical staff should provide, at a minimum, the following:

- Carefully explain to each patient their current medical condition, including the treatment plan they should follow;
- Provide referrals for medical, mental health and drug addiction treatment in the community and insure that patients understand how to access these referrals;
- Provide sufficient doses of medicine for chronic conditions to allow patients to continue their medical care while they seek treatment in the community;
- Make appointments for patients with chronic medical problems so they can be treated after their release;
- Provide copies of medical records to the patients so their treatment is not delayed;
- Provide contact information so that community providers will have access to medical providers within corrections if they need to communicate about a patient's medical condition;
- Coordinate with community providers and departments of public health and mental health to insure that patients do not slip through the cracks.

Providing adequate discharge planning for prisoners as they leave correctional institutions is an opportunity to address what are often very significant public health issues. Not only may these patients have diseases that require appropriate intervention, but it is an opportunity to treat a population that is often elusive, from a public health perspective.

Finally, it is critical for medical and mental health staff within correctional facilities to collaborate and coordinate with agencies in the community that provide critical care. We urge state and city agencies to devise ways to create effective partnerships in order to better serve this group of citizens which so critically needs the care that they can provide. This could include granting access to community providers to come into prisons and jails prior to an inmate's release to insure continuity in medical care after their release. There have been some pilot projects that indicate that this model can be very successful in insuring that patients receive critical care after they return to the community. One example is the project conducted by the Baltimore Mental Health Systems to provide case management and discharge services at the Patuxent Facility.

We applaud the efforts of this Task Force to investigate the very serious medical and mental health needs of a portion of our community which often has no voice and is forced to suffer serious illness in silence. We look forward to partnering with you to provide an effective solution to these significant needs.

National Health Care for the Homeless Council
Policy Statement

Incarceration, Homelessness and Health
June 2001

"Prisons...are only a problem for those locked inside of them, their loved ones, and those who want a free society."[1]

- Joel Olson

Summary of Recommendations

- *Decriminalize the condition of homelessness; repeal Federal, state and local statutes that criminalize private activities in public spaces.*
- *Ensure continuity of health care services for those detained by criminal justice authorities. Jail and prison health personnel should proactively assure the maintenance of health services including addiction treatment and medications for chronic illnesses.*
- *Guarantee, prior to their discharge from correctional facilities, the availability of appropriate housing and health care services including addiction and mental health services for former prisoners.*

Homelessness and Incarceration

The U.S. incarcerates a larger proportion of its population than any other nation. Over two million Americans, 725 of every 100,000 people, are in jail or prison. An additional 5.7 million people are on parole or probation. The relationship between homelessness and incarceration has grown complex over the past several decades:

Homelessness is increasingly likely to be a cause of incarceration, as local jurisdictions adopt ordinances that criminalize common activities such as sleeping, standing, or begging in public spaces. People without homes frequently face arrest for public "nuisance" crimes such as public urination, indecency or intoxication. People with homes do not tend to be prosecuted for these behaviors.

Incarceration often results in homelessness. People leave jails and prisons without a destination, bereft of the resources necessary to secure housing or health care. Given the dearth of community housing, emergency shelter, mental health services, addiction treatment, and primary health care resources, many former prisoners have few places to turn other than shelters and the streets.

Large proportions of people with mental illness are likely to be imprisoned. Given reduced availability of appropriate long-term mental health and addiction treatment facilities, many people with mental illness and addictions are incarcerated in prisons and jails. People with mental illness are 64 percent more likely to be arrested than those without a mental illness for

[1] Olson, Joel, "Gardens of the Law: The Role of Prisons in Capitalist Society", Crisis, www.prisonactivist.org.

committing the same crime.[2] Nationally 16 percent of prisoners in state prisons and local jails have a mental illness totaling nearly 300,000 people, or four times the number of Americans in state mental hospitals.[3] Certain localities have a national reputation for jailing the mentally ill. Los Angeles County Jail, for example, is said to be the largest mental health facility in the U.S. Community-based resources for people with mental illness remain insufficient.

Large proportions of people with addictions are likely to be imprisoned. People who use addictive substances total 80 percent of the prison and jail population,[4] and yet only 13 percent of those identified as needing treatment ever receive it while incarcerated.[5] Without considering detoxification, most incarcerated people have never received addiction treatment in the community.[6]

Race is a determinant in the likelihood of incarceration. African Americans, Latinos and other "minority" populations are disproportionately incarcerated in jails in prisons. One of three African American men in the U.S. will be incarcerated during their lifetimes.[7]

Incarceration as Social Policy

Incarceration has become one of the most frequently used mechanisms to solve social problems. The "law and order" model of governance, popularized by politicians locally (e.g. Mayor Giuliani of New York City) and on the national scene (e.g. President George W. Bush who, as Governor of Texas, presided over nearly 150 executions), has resulted in the concentration of public dollars on law enforcement activities. Spending for prisons now consumes a disproportionate share of public budgets, costing nearly $130 billion in 1997.[8] Cities such as Baltimore are closing libraries and schools to pay for police helicopters, high-tech eavesdropping equipment, and larger police forces.

Incarceration as social policy is bipartisan. Rates of incarceration have climbed dramatically under both Democratic and Republican administrations. Nationwide 673,000 people entered federal and state prisons and local jails during the Clinton Administration, as compared to 148,000 during the Reagan Administration. Furthermore, the Clinton Administration was responsible for an unprecedented growth of the federal prison population, which grew by 66,987, to 147,126. During the previous 12 years of Republican administrations, the number of prisoners under federal jurisdiction rose by 55,896.[9]

The "Prison Industrial Complex." The focus of public policy on incarcerating the poor has led to the phenomenon of the "prison industrial complex." Angela Davis, a researcher and professor

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[2] Bazelon Center for Mental Health Law, April, 2001: www.bazelon.org
[3] National Alliance for the Mentally Ill, 1999.
[4] National Clearinghouse for Alcohol and Drug Information: www.health.org/govpubs/BKD308/30d.htm
[5] Ibid.
[6] Lipton, et al., 1989; Peyton, 1994)
[7] "Ten Things You Should Know about Prisons in the U.S.", Oberlin Action Against Prisons, n.d.
[8] "Percent Distribution of Expenditure for the Justice System by Level of Government", Justice Expenditure and Employment Extracts, 1997, NCJ 185672, found at www.ojp.usdoj.gov/bjs/eande.htm#select
[9] "Too Little Too Late: President Clinton's Prison Legacy", Justice Policy Institute, 2/19/01.

at the University of California, defines the "prison industrial complex" as the nexus of the enormous growth in the number and size of jails and prisons; the increasing privatization of incarceration; the importance of prisons as economic factors for small, often rural, communities; and "the collaboration of politicians and the corporate-controlled dominant media in the wholesale *criminalization* of communities of color (and particularly youth of color) and in the representation of prisons as catch-all solutions to social problems."[10]

The* criminalization *of homelessness adds the element of class to the social jeopardy of race. People experiencing homelessness are targeted for arrest not only because they frequently are people of color, but also because they represent most visibly the maldistribution of wealth. The reality of homelessness announces that the wealthiest nation in the history of the world is unable to meet the most basic needs of a significant proportion of its residents. In the context of the prison industrial complex, this becomes another social (and economic/political) problem to be solved by incarceration.

Of course people experiencing homelessness are not imprisoned solely because of their social status; they are also likely to violate laws which criminalize the use of drugs (58 percent of federal prisoners are serving time for drug offenses), illegally enter abandoned housing, carry no identifying documents (becoming subject to arrest as a "rogue and vagabond"), or be arrested as a result of mental illness. Once arrested, people experiencing homelessness are less likely to be released prior to trial, as they frequently cannot afford bail and have no address to which they may be released.

Health, Homelessness, and Incarceration

Homelessness is a health hazard, in part because it impedes access to health services. Incarceration further compromises the health of people experiencing homelessness. Those who had been receiving health care are unlikely to continue receiving treatment or medication in jail or prison. This is particularly harmful to people with life-threatening, chronic illnesses such as HIV, diabetes, and hypertension, all of which have heightened prevalence among people experiencing homelessness. Disruption of treatment is also harmful to people with mental illness and addictions: anti-psychotic medications often are discontinued upon incarceration; people with addictions may be faced with the dangers of involuntary, unsupervised detoxification.

In addition to the disruption of health care, incarceration poses other serious health problems. Communicable diseases such as hepatitis are common in prison.[11] Violence is also prevalent; for example, 21 percent of prisoners reported experiencing forced sexual contact in a recent survey.[12]

No Direction Home

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[10] "What is the Prison Industrial Complex", Prison Activist Resource Center, www.prisonactivist.org

[11] "The prevalence of this disease is believed to be 30 to 40 percent of the prison population.:" Elsner, Alan, "Hepatitis C spreads mostly unchecked in prisons", Reuters, 4/5/01.

[12] Lewin, Tamar, "Little sympathy or remedy for inmates who are raped", *The New York Times*, 4/15.01, A1.

Housing Resources: Jails and prisons are guided by no legal requirement to develop and implement discharge plans for those leaving their custody and community resources are insufficient to meet the needs of those leaving correctional facilities. Consequently, for too many people, release from prison offers the negative freedom associated with the absence of restrictions. Positive freedom, the actual capacity to achieve one's goals, or even to meet one's basic needs, remains an illusion without shelter, income, or health care. Most often, people who had been homeless upon arrest are homeless upon discharge. An additional number of people who *had* been housed when arrested *become* homeless when discharged. They may have been evicted while incarcerated, or they no longer may be welcome at their former residence. Public housing agencies are permitted to deny housing assistance to people with criminal records.

Health Care: People leaving jails and prisons rarely have immediate access to health services. The medical records of released prisoners do not accompany them outside the prison walls. Without adequate health insurance, many former prisoners lack the ability to follow up with health professionals, including addiction counselors and mental health therapists, or to obtain medications that may have been prescribed during incarceration.

Incomes: Incomes for released prisoners are a special challenge. Employment or disability assistance typically is disrupted by arrest. Eligibility for public benefits therefore must be re-established upon release, and public assistance benefits may be withheld from people with criminal records. (The Bazelon Center for Mental Health Law has published a booklet that explains federal rules governing access to public programs such as Supplemental Security Income (SSI) for those leaving correctional facilities.[13]) Additionally, ex-offenders often encounter legally-sanctioned discrimination from employers.

Recommendations

1. ***Decriminalize the condition of homelessness; repeal Federal, state and local statutes that criminalize private activities in public spaces.***

In an increasing number of localities, activities associated with homelessness and poverty are declared illegal. Many local governments adopt ordinances that prohibit sleeping on sidewalks, begging in public, even placing one's belongings under park benches. These acts are punished with jail sentences. Other ordinances, such prohibitions against loitering and drinking in public, may be selectively enforced, resulting in the arrest of people experiencing homelessness. These unnecessary arrests lead to the incarceration-related disruptions discussed above and complicate access to housing and employment. Communities should work to reverse policies resulting in the incarceration of those in need of greater social supports.

2. ***Ensure continuity of health care services for those detained by criminal justice authorities. Jail and prison health personnel should assure the maintenance of health services such as medications for chronic illnesses.***

[13] Bazelon Center for Mental Health Law, 2001 www.bazelon.org/pubs.html

As noted above, people receiving health care services prior to arrest often experience the disruption of these services in jail or prison. This may exacerbate serious health problems, including mental illness and addiction. Health care providers in penal institutions should coordinate closely with community-based providers to continue appropriate services, including psychotropic drugs, addiction treatment and HIV medications while incarcerated.

3. ***Guarantee, prior to their discharge from correctional facilities, the availability of appropriate housing and health care services including addiction and mental health services for former prisoners.***

Jail and prison personnel should have robust linkages with community resources, enabling people leaving penal facilities to secure housing immediately. Eligibility for public benefits should be determined prior to release, in order that these benefits will be available as soon as needed. Eligibility for public benefits, including subsidized housing, should be restored for ex-offenders. Finally, localities should arrange a seamless transition to community-based health service providers.

Baltimore
MENTAL HEALTH SYSTEMS, INC.

My name is Steve Baron and I'm the president of Baltimore Mental Health Systems, Inc. (BMHS). I'm here to speak about the mental health needs of incarcerated individuals. BMHS is the local mental health authority for Baltimore City and was established by city government as a public nonprofit agency to manage the city's Public Mental Health System (PMHS). We are responsible for administering, funding, planning and monitoring a network of providers that deliver services to more than 23,000 Baltimore City residents.

Unfortunately we know very little about the needs of released inmates on the local level. Data that we have from the Bureau of Justice Statistics is from State and federal prison releases and that data shows that the rate of mental disorder in the prison population is 2 to 3 times of the general population. In state prisons it is about 16% of the prison population and 7% of the federal prison population. In addition, 80% of the state prison population report a history of drug and or alcohol use.

Co-occurring disorders of substance abuse and mental illness are common. More than one-third of state inmates with mental illness have a history of alcohol dependence and 60% of these individuals indicate that they were under the influence of alcohol or drugs at the time of the offense.

Inmates with serious mental illnesses are at risk to become homeless upon release as loss of Medicaid and other benefits during incarceration increase the risk of homelessness.

Examples of what we are doing:

Located with the Medical Services of the Circuit Court, BMHS supports the Forensic Assessment Services Team (FAST). FAST works with the District Court to provide consultation and development of community placement plans as an alternative to incarceration and works with mentally ill repeat offenders in Baltimore City Detention Center (BCDC) to develop appropriate community services.

In collaboration with the Department of Corrections (DOC), BMHS has developed an initiative where community providers work with inmates at Patuxent Institute at least 3 months prior to release. This enables time for the development of realistic community services plan that address housing, entitlements, employment, treatment, family and community integration to be addressed.

What we are recommending:

1. A more complete needs assessment of the mental health needs of

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Website: http://www.bmhsi.org

individuals currently at BCDC. Since 70% of the individuals detained at BCDC come directly back to the community we expect that there is significant number of individuals with mental health needs which require a range of services.

2. Organized training of correctional staff to recognize behavioral needs. A recent Associated Press (AP) story released July 15, 2001 stated that only 70% of state prisons screen inmates for mental illness as a matter of policy and only 10% of male inmates receive any treatment.

3. Ensure treatment begins while the individual is incarcerated with appropriate and prompt access to psychiatrists and medicines. For example, BCDC does not begin medication for incarcerated individuals until after bail review. This policy allows individuals remain symptomatic unnecessarily.

4. Require comprehensive discharge planning that addresses psychiatric needs as well as community supports that are well-coordinated with community providers.

5. Plan incentives for community providers to offer a range of services for individuals released from DOC facilities.

6. Require state agencies to prioritize population and develop plans to address needs.

Testimony before the Maryland Task Force to Study the Health Care Needs of Inmates in Transition from Correctional Institutions

submitted by Aurie Hall, Program Officer
Criminal Justice Program
Open Society Institute – Baltimore
July 19, 2001

Good evening. My name is Aurie Hall. I am the Program Officer for the Criminal Justice Program of the Open Society Institute – Baltimore. The Open Society Institute is a foundation created and funded by George Soros, an international financier. The foundation operates in over 30 foreign countries and in the United States. Baltimore is the only U.S. field office of the foundation, which is headquartered in New York City.

The goal of the Open Society Institute is to encourage the development of civil society in America and around the world. Because we believe it is important for every member to participate in society, the Open Society Institute – Baltimore focuses our criminal justice funding on the successful reintegration of ex-offenders into the community. Successful reintegration is also in the public interest because if ex-offenders have the means to support themselves, they are less likely to return to criminal activity. Once people have paid their required debt to society, we should help them return to their communities and engage in the civic and economic life of the community in a productive manner. The ability to access necessary health care is critical to becoming a productive member of society. We all lose if we create a shadow society of people who are denied basic needs because they have been incarcerated.

Health and Mental Health Care Needs of Newly Released Inmates

Health care and mental health care are basic needs that must be addressed as people are released from prison or jail. Unfortunately, the incarcerated population suffers from higher rates of health problems, including hypertension, diabetes, HIV/AIDS, sexually transmitted diseases, tuberculosis, drug addiction, and mental illness than the population at large. Many of these health problems occur at higher rates due to years of living in poverty, which results in inadequate diet and lack of access to appropriate medical treatment. Many of these medical problems also represent significant public health problems, and therefore everyone in the community has a stake in insuring that people receive adequate treatment, both before and after their release from prison.

In general, the correctional system currently does not provide standard discharge planning services to inmates. Medical staff do not conduct exit interviews to insure that prisoners understand the nature of their medical

problems and the treatment regimen they need to pursue upon their release. Prisoners are not given referrals to medical treatment facilities in the communities where they are returning and are not provided copies of their medical records. This practice makes it extremely difficult for ex-prisoners to access health care providers in the community, because they do not have critical information about their current medical condition or treatment.

There is little coordination between corrections and the agencies that provide drug addiction treatment and mental health treatment. Prisoners suffer from both drug addiction and mental illness at much higher rates than the general public and both of these conditions, if left untreated, can have a significant adverse impact on public health and public safety.

We recommend that the Department of Public Safety and Correctional Services insure that medical staff in correctional facilities conduct adequate discharge planning with patients prior to their release from prison and jail. When medical services are provided through contracted vendors, a requirement to conduct appropriate discharge planning should be included in their contract. Medical staff should provide, at a minimum, the following:

- Carefully explain to each patient their current medical condition, including the treatment plan they should follow;
- Provide referrals for medical, mental health and drug addiction treatment in the community and insure that patients understand how to access these referrals;
- Provide sufficient doses of medicine for chronic conditions to allow patients to continue their medical care while they seek treatment in the community;
- Make appointments for patients with chronic medical problems so they can be treated after their release;
- Provide copies of medical records to the patients so their treatment is not delayed;
- Provide contact information so that community providers will have access to medical providers within corrections if they need to communicate about a patient's medical condition;
- Coordinate with community providers and departments of public health and mental health to insure that patients do not slip through the cracks.

Providing adequate discharge planning for prisoners as they leave correctional institutions is an opportunity to address what are often very significant public health issues. Not only may these patients have diseases that require appropriate intervention, but it is an opportunity to treat a population that is often elusive, from a public health perspective.

Finally, it is critical for medical and mental health staff within correctional facilities to collaborate and coordinate with agencies in the community that provide critical care. We urge state and city agencies to devise ways to create effective partnerships in order to better serve this group of citizens which so critically needs the care that they can provide. This could include granting access to community providers to come into prisons and jails prior to an inmate's release to insure continuity in medical care after their release. There have been some pilot projects that indicate that this model can be very successful in insuring that patients receive critical care after they return to the community. One example is the project conducted by the Baltimore Mental Health Systems to provide case management and discharge services at the Patuxent Facility.

We applaud the efforts of this Task Force to investigate the very serious medical and mental health needs of a portion of our community which often has no voice and is forced to suffer serious illness in silence. We look forward to partnering with you to provide an effective solution to these significant needs.

CITY OF BALTIMORE

MARTIN O'MALLEY, Mayor

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

PAUL T. GRAZIANO, Commissioner
P.O. Box 236
417 East Fayette Street
Baltimore, Maryland 21203-0236

July 19, 2001

Delegate Rudolph C. Cane
Lowe House Office Building
Room 414
Annapolis, MD 21401-1991

Del. Cane:

Thank you for the opportunity to speak on the health care needs of individuals in transition. I am the Director of the Office of Homeless Services for Baltimore City and oversee the administration of Federal, State and local funds to provide a Continuum of Care for those at risk of or experiencing homelessness. We have the unfortunate distinction of being the home to 56.7% of the state's homeless population. On any given night that means up to 3,000 individuals; in a given year that is over 30,000. A recent study within our homeless population showed that 69% of the men and 57% of the women has a history of incarceration. And their health care needs are staggering.

Data coming from Philadelphia indicates that the age adjusted mortality rate of a homeless individual is 3.5 time higher than the general population. The most common reasons for death are injury (21%), heart disease (19%), liver disease (8%), and poisoning or overdose (8%). The homeless are admitted to an acute care hospital 5 times more often than the general population and a psychiatric hospital 100 time more often. Resources are being thrown at this population but the cost effectiveness is terrible.

The sheltered homeless utilize health services more that the unsheltered homeless. The unsheltered are more likely to use trauma and acute care services. If trauma rates are to be reduced in order to focus on the management of chronic diseases, housing arrangements must be met. But what were the reasons for not seeking health care when it was needed? Frequent responses were a lack of transportation and previous providers asking to many questions but no follow-up. This raises questions about how health care is delivered.

We do have some examples of successful programs. Within our system of emergency shelter providers, we are funding two facilities to house individuals who are in need of convalescent care. These are individuals who were in

hospitals but were released with no housing plan – except perhaps 2000 Broadway, our local DSS office, or Health Care for the Homeless. Sixty-seven women and 196 men were housed over the last year; 65 individuals were turned away due to their need for skilled care. Men stayed an average of 19 days; women 39 days. Most frequent primary diagnoses included dermatological, musculoskeletal and respiratory concerns; secondary diagnoses included gastrointestinal, psychiatric and cardiovascular issues. These are not issues our shelters are prepared to deal with – nor should they.

In 2000, we won a competitive award to provide pre-release case management and transitional housing to HIV+ individuals in the prison system. Beginning in April 2000 through May 2001, 91 individuals have been referred to this program out of 4 prisons; 52 are participating in the program, 23 of who are in prison. Many of the clients were diagnosed while in prison and have not dealt with issues on-going health care or even around disclosure. While there continue to be some systemic issues with knowing when an inmate is released and transferring medical records, most of the clients' greatest need is drug treatment in addition to identifiaton and treatment of Hepatitis C or other STDs and the often present depression.

It is no longer an issue of what we can do but what we must do.

- We must provider access to medical services where the individuals are – sheltered or unsheltered.
- We must provide access to appropriate medical services through the development of more convalescent resources.
- We must provide seamless transitional of medical services as individuals move from prisons.

I thank you for your concern and your attention to this issue. I look forward to helping you as you move towards identifying and implementing effective and long-term health care solutions.

Sincerely,

Leslie Leitch, Director
Office of Homeless Services

SALIMA SILER MARRIOTT
40th Legislative District
Baltimore City

Chair
Baltimore City Delegation

Member
Ways and Means Committee

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TESTIMONY BEFORE THETASK FORCE TO ASSESS THE HEALTH NEEDS OF NEWLY RELEASED INMATES

JULY 19, 2001

The work of this task for on the health needs of newly released inmates is extremely valuable. However, the needs of newly released inmates transcend health. Efforts to establish a more comprehensive approach have thwarted in the Maryland Senate as has all progressive approaches to correct the wrongs in our system of implementing criminal law.

The increasing rates of incarceration and the subsequent growing numbers of released inmates returning to their communities raise serious concerns about their achieving a successful transition. Maryland, with the 12th highest incarceration rate in the country, has more than 23,000 individuals in the state prison system, and in recent years has released some 13,500 each year. There are 27 county jails with a capacity of 10,500. The Baltimore City Detention Center has an average stay of 3.4 months, admits some 250 inmates each day and releases about 43,000 individuals per year. Ninety percent of all inmates will eventually be released back into the community.

Not only do their numbers pose an unprecedented challenge to the supporting social service systems, without well integrated transitional services, these numbers pose a very serious public safety threat. Our society's tough on crime and war on drugs drives over the past twenty years have focused on incarceration and increase sentencing. We have failed to seriously address the return of ex-offenders to the community. There seems to be an assumption that incarceration provides an opportunity for rehabilitation and restoration. This absolutely is not the case for most individuals returning. When educational, training and opportunities for work exist, there is little coordination or bridging from the institution to the community where the individuals will returns.

There is a current crisis in addressing the most basic need of educational services for incarcerated individuals. Maryland law mandates school for inmates who do not have a high school diploma and have at least 18 months to serve. Federal law requires special education services in prison for those who are determined eligible. During FY 2000, 19,800 inmates were eligible for state and federally mandated education programs, but only 9,300 received services. Two thousand one hundred forty-four inmates were on waiting lists on September 15, 2000.

Research has shown a 19% drop in recidivism for Maryland inmates who participated education programs during incarceration. Research also shows that transitional services enhance the probability of success and reduction of recidivism. Maryland has few resources for transition.

Newly released inmates is the sickest population in the country with the highest prevalence of HIV/AIDS, Hepatitis C, syphilis, gun wound-related colostomies, and orthopedic and neurologic conditions, psychotic character disorders and psychopathic personalities. All of these health conditions are compounded by educational deficits, employment difficulties and patterns of social and individual alienation. This is a historically new situation, having developed over the last 20 years, that requires a new look.

The purpose of this Task Force is to use an integrated approach to assessing the needs and designing a systemic strategy to meet the needs of the population of individuals being released from prisons and jails in Maryland. Responding to the needs of newly released inmates is a harm reduction strategy for citizens of Maryland and cost effective for the State. Reduction in crime reduces cost of law enforcement, judicial process and incarceration. When we invest $12,000,000 in prison education, the drop in recidivism saves about $24,000. It allows us to invest in other community enhancing strategies.

I come to appealing to this Task Force requesting that you recommend extending your duration and expanding your mission to a more comprehensive approach to address the needs of newly released inmates.

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- Joel Olson

Summary of Recommendations

- *Decriminalize the condition of homelessness; repeal Federal, state and local statutes that criminalize private activities in public spaces.*
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- *Guarantee, prior to their discharge from correctional facilities, the availability of appropriate housing and health care services including addiction and mental health services for former prisoners.*

Homelessness and Incarceration

The U.S. incarcerates a larger proportion of its population than any other nation. Over two million Americans, 725 of every 100,000 people, are in jail or prison. An additional 5.7 million people are on parole or probation. The relationship between homelessness and incarceration has grown complex over the past several decades:

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Incarceration often results in homelessness. People leave jails and prisons without a destination, bereft of the resources necessary to secure housing or health care. Given the dearth of community housing, emergency shelter, mental health services, addiction treatment, and primary health care resources, many former prisoners have few places to turn other than shelters and the streets.

Large proportions of people with mental illness are likely to be imprisoned. Given reduced availability of appropriate long-term mental health and addiction treatment facilities, many people with mental illness and addictions are incarcerated in prisons and jails. People with mental illness are 64 percent more likely to be arrested than those without a mental illness for

[1] Olson, Joel, "Gardens of the Law: The Role of Prisons in Capitalist Society", Crisis, www.prisonactivist.org.

committing the same crime.[2] Nationally 16 percent of prisoners in state prisons and local jails have a mental illness totaling nearly 300,000 people, or four times the number of Americans in state mental hospitals.[3] Certain localities have a national reputation for jailing the mentally ill. Los Angeles County Jail, for example, is said to be the largest mental health facility in the U.S. Community-based resources for people with mental illness remain insufficient.

Large proportions of people with addictions are likely to be imprisoned. People who use addictive substances total 80 percent of the prison and jail population,[4] and yet only 13 percent of those identified as needing treatment ever receive it while incarcerated.[5] Without considering detoxification, most incarcerated people have never received addiction treatment in the community.[6]

Race is a determinant in the likelihood of incarceration. African Americans, Latinos and other "minority" populations are disproportionately incarcerated in jails in prisons. One of three African American men in the U.S. will be incarcerated during their lifetimes.[7]

Incarceration as Social Policy

Incarceration has become one of the most frequently used mechanisms to solve social problems. The "law and order" model of governance, popularized by politicians locally (e.g. Mayor Giuliani of New York City) and on the national scene (e.g. President George W. Bush who, as Governor of Texas, presided over nearly 150 executions), has resulted in the concentration of public dollars on law enforcement activities. Spending for prisons now consumes a disproportionate share of public budgets, costing nearly $130 billion in 1997.[8] Cities such as Baltimore are closing libraries and schools to pay for police helicopters, high-tech eavesdropping equipment, and larger police forces.

Incarceration as social policy is bipartisan. Rates of incarceration have climbed dramatically under both Democratic and Republican administrations. Nationwide 673,000 people entered federal and state prisons and local jails during the Clinton Administration, as compared to 148,000 during the Reagan Administration. Furthermore, the Clinton Administration was responsible for an unprecedented growth of the federal prison population, which grew by 66,987, to 147,126. During the previous 12 years of Republican administrations, the number of prisoners under federal jurisdiction rose by 55,896.[9]

The "Prison Industrial Complex." The focus of public policy on incarcerating the poor has led to the phenomenon of the "prison industrial complex." Angela Davis, a researcher and professor

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[2] Bazelon Center for Mental Health Law, April, 2001: www.bazelon.org
[3] National Alliance for the Mentally Ill, 1999.
[4] National Clearinghouse for Alcohol and Drug Information: www.health.org/govpubs/BKD308/30d.htm
[5] Ibid.
[6] Lipton, et al., 1989; Peyton, 1994)
[7] "Ten Things You Should Know about Prisons in the U.S.", Oberlin Action Against Prisons, n.d.
[8] "Percent Distribution of Expenditure for the Justice System by Level of Government", Justice Expenditure and Employment Extracts, 1997, NCJ 185672, found at www.ojp.usdoj.gov/bjs/eande.htm#select
[9] "Too Little Too Late: President Clinton's Prison Legacy", Justice Policy Institute, 2/19/01.

at the University of California, defines the "prison industrial complex" as the nexus of the enormous growth in the number and size of jails and prisons; the increasing privatization of incarceration; the importance of prisons as economic factors for small, often rural, communities; and "the collaboration of politicians and the corporate-controlled dominant media in the wholesale *criminalization* of communities of color (and particularly youth of color) and in the representation of prisons as catch-all solutions to social problems."[10]

The* criminalization *of homelessness adds the element of class to the social jeopardy of race. People experiencing homelessness are targeted for arrest not only because they frequently are people of color, but also because they represent most visibly the maldistribution of wealth. The reality of homelessness announces that the wealthiest nation in the history of the world is unable to meet the most basic needs of a significant proportion of its residents. In the context of the prison industrial complex, this becomes another social (and economic/political) problem to be solved by incarceration.

Of course people experiencing homelessness are not imprisoned solely because of their social status; they are also likely to violate laws which criminalize the use of drugs (58 percent of federal prisoners are serving time for drug offenses), illegally enter abandoned housing, carry no identifying documents (becoming subject to arrest as a "rogue and vagabond"), or be arrested as a result of mental illness. Once arrested, people experiencing homelessness are less likely to be released prior to trial, as they frequently cannot afford bail and have no address to which they may be released.

Health, Homelessness, and Incarceration

Homelessness is a health hazard, in part because it impedes access to health services. Incarceration further compromises the health of people experiencing homelessness. Those who had been receiving health care are unlikely to continue receiving treatment or medication in jail or prison. This is particularly harmful to people with life-threatening, chronic illnesses such as HIV, diabetes, and hypertension, all of which have heightened prevalence among people experiencing homelessness. Disruption of treatment is also harmful to people with mental illness and addictions: anti-psychotic medications often are discontinued upon incarceration; people with addictions may be faced with the dangers of involuntary, unsupervised detoxification.

In addition to the disruption of health care, incarceration poses other serious health problems. Communicable diseases such as hepatitis are common in prison.[11] Violence is also prevalent; for example, 21 percent of prisoners reported experiencing forced sexual contact in a recent survey.[12]

No Direction Home

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[10] "What is the Prison Industrial Complex", Prison Activist Resource Center, www.prisonactivist.org

[11] "The prevalence of this disease is believed to be 30 to 40 percent of the prison population.:" Elsner, Alan, "Hepatitis C spreads mostly unchecked in prisons", Reuters, 4/5/01.

[12] Lewin, Tamar, "Little sympathy or remedy for inmates who are raped", *The New York Times*, 4/15/01, A1.

Housing Resources: Jails and prisons are guided by no legal requirement to develop and implement discharge plans for those leaving their custody and community resources are insufficient to meet the needs of those leaving correctional facilities. Consequently, for too many people, release from prison offers the negative freedom associated with the absence of restrictions. Positive freedom, the actual capacity to achieve one's goals, or even to meet one's basic needs, remains an illusion without shelter, income, or health care. Most often, people who had been homeless upon arrest are homeless upon discharge. An additional number of people who *had* been housed when arrested *become* homeless when discharged. They may have been evicted while incarcerated, or they no longer may be welcome at their former residence. Public housing agencies are permitted to deny housing assistance to people with criminal records.

Health Care: People leaving jails and prisons rarely have immediate access to health services. The medical records of released prisoners do not accompany them outside the prison walls. Without adequate health insurance, many former prisoners lack the ability to follow up with health professionals, including addiction counselors and mental health therapists, or to obtain medications that may have been prescribed during incarceration.

Incomes: Incomes for released prisoners are a special challenge. Employment or disability assistance typically is disrupted by arrest. Eligibility for public benefits therefore must be re-established upon release, and public assistance benefits may be withheld from people with criminal records. (The Bazelon Center for Mental Health Law has published a booklet that explains federal rules governing access to public programs such as Supplemental Security Income (SSI) for those leaving correctional facilities.[13]) Additionally, ex-offenders often encounter legally-sanctioned discrimination from employers.

Recommendations

1. ***Decriminalize the condition of homelessness; repeal Federal, state and local statutes that criminalize private activities in public spaces.***

In an increasing number of localities, activities associated with homelessness and poverty are declared illegal. Many local governments adopt ordinances that prohibit sleeping on sidewalks, begging in public, even placing one's belongings under park benches. These acts are punished with jail sentences. Other ordinances, such prohibitions against loitering and drinking in public, may be selectively enforced, resulting in the arrest of people experiencing homelessness. These unnecessary arrests lead to the incarceration-related disruptions discussed above and complicate access to housing and employment. Communities should work to reverse policies resulting in the incarceration of those in need of greater social supports.

2. ***Ensure continuity of health care services for those detained by criminal justice authorities. Jail and prison health personnel should assure the maintenance of health services such as medications for chronic illnesses.***

[13] Bazelon Center for Mental Health Law, 2001 www.bazelon.org/pubs.html

As noted above, people receiving health care services prior to arrest often experience the disruption of these services in jail or prison. This may exacerbate serious health problems, including mental illness and addiction. Health care providers in penal institutions should coordinate closely with community-based providers to continue appropriate services, including psychotropic drugs, addiction treatment and HIV medications while incarcerated.

3. ***Guarantee, prior to their discharge from correctional facilities, the availability of appropriate housing and health care services including addiction and mental health services for former prisoners.***

Jail and prison personnel should have robust linkages with community resources, enabling people leaving penal facilities to secure housing immediately. Eligibility for public benefits should be determined prior to release, in order that these benefits will be available as soon as needed. Eligibility for public benefits, including subsidized housing, should be restored for ex-offenders. Finally, localities should arrange a seamless transition to community-based health service providers.